

JOINT HEARING TO RECEIVE LEGISLATIVE PRESENTATIONS FROM NASDVA, FRA, GSW, BVA, JWV, MOPH, AND MOAA

JOINT HEARING
OF THE
COMMITTEE ON VETERANS' AFFAIRS
BEFORE THE
U.S. SENATE
AND THE
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTEENTH CONGRESS
FIRST SESSION

MARCH 12, 2019

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TUESDAY, MARCH 12, 2019

UNITED STATES SENATE,
AND HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committees met, pursuant to notice, at 10:00 a.m., in Room SD-G50, Dirksen Senate Office Building, Hon. Johnny Isakson and Hon. Mark Takano, Chairmen of the Committees, presiding.

Senators Present: Senators Isakson, Boozman, Rounds, Sullivan, Blackburn, Tester, Brown, Blumenthal, and Sinema.

Representatives Present: Representatives Takano, Lamb, Rose, Brindisi, Cisneros, Lee, Underwood, Cunningham, Pappas, Allred, Sablan, Roe, and Bost.

OPENING STATEMENT OF CHAIRMAN ISAKSON

Chairman ISAKSON. I call the Veterans' Affairs Committee to order.

It looks like a lot of us are not here, and that is the way you should judge it. But we are coming fast, so just hang on. You are not going to be stuck with me for the whole day. We will get some others here in a few minutes. There is some on the way.

Chairman Roe—or last year's chairman, Chairman Roe, from the House is on the way. Mr. Tester from Montana will be here shortly, and Mr. Takano from the House, the Chairman, will be here as well.

So I will start out, and when they come in, we will continue. And we start to ask members as we speak, which is great. Welcome. Glad to have you.

Let me thank all of you for being here today. This is the fifth, I believe—is that right, Adam?—hearing. It is our fifth hearing. We have heard from a lot of vets. We had not heard from you. There is an old saying if everybody has heard everything that had to be said, everybody has not said it, but I am sure we are going to learn some things new here from you today. And we appreciate your being here.

For the benefit of the audience that is here, as well as each of the representatives that are here, we sent a letter to every VSO explaining that if we had a hearing for each individual VSO, we would be meeting into the month of April. And it would be impos-

sible to do our work. So we consolidated a couple of them, and yours is one of them.

But everybody was asked to submit their testimony in writing, and that is being included for the record as well. So anybody who is interested in the positions of your representation and your group will be able to get it from the offices, from our Committee office and from the Senate.

You are very important, each one of you, to us. The United States of America is a great country for a lot of reasons but none greater than its veterans, those who volunteered, risk their lives for the people of the United States of America and for all of us here.

We know on this Committee, House and Senate. We are a bipartisan committee, and I can speak for the House because I know the exact numbers. We passed everything last year almost unanimously, with one dissenting vote, on the MISSION Act. That was pretty good for a committee almost equally divided with Republicans and Democrats, but we do not think there were any Republicans on the battlefield or Democrats of the battlefield. They were Americans on the battlefield. So we do not discriminate based on what you joined and what uniform you wore, how old you were, the color of your skin or anything else. We pay honor to those who risked their lives for the United States of America and the people.

And one thing I want to make sure we do is that the benefits that you are entitled to when you enlisted, that you get those benefits in as least cumbersome way as possible and as timely a way as possible.

We all know that the MISSION Act, which we passed this past year, was primarily focused on getting our problems with the Choice in the VA out, getting Choice meaningful for private or VA providers, making it work in a seamless fashion for each of you.

I want to underscore you—and every chairman has said this in every meeting. So I am speaking for all four of us, the “four corners,” as we call it. We have no interest in privatizing the VA; we have every interest in making the VA the best health care it can possibly be.

[Applause.]

Chairman ISAKSON. He always comes in when the clapping starts.

[Laughter.]

Chairman ISAKSON. Those people from Tennessee, I will tell you.

But, anyway, we have all stated that when it has been our turn to testify in every one of these hearings, but we also know that there is no way you can have good quality health care available to every single veteran without using the empowerment of the private sector, and that is what Choice does. If you cannot get to a caregiver or if there is a specialty you cannot get to reasonably accessible, you pick one that is.

And we are getting those access standards being done now. In fact, the access standards to private care was just released by the VA a couple days ago for talking points, which we will be testifying on shortly, and they are aimed to make it easier, faster, and more efficient for you to do that. And we are aimed at seeing to it that providers do the same, and TriWest is going to be doing our place-

ment on that too as well. And we have told them in no uncertain terms that speed and efficiency and good care are the absolute requirements of everything.

We want to measure the VA's health care based on quantity and quality, not just quantity, but quantity and quality. We want to make sure you get the best care, make sure it is readily available so you do not have to wait on it.

You have all risked your life for us or put your life on the line for us. There is nothing we can do but see to it you get all the benefits that are there to do so.

So I am pleased to welcome all of you here today to Washington. I appreciate you coming and sharing your time.

The way we will operate is I am going to introduce the other members of the four corners of the Chairs and Ranking Members to make an opening statement, and then we will go to the members for questions after the opening remarks are going to be made.

The opening remarks are going to be made by—I guess each one of you are going to make remarks about your particular group. Is that right? Is that what we are going to do? Yeah. So each one of you will be prepared. Those remarks will be limited to a maximum of 5 minutes.

I can tell you, the Veterans of Foreign Wars, I did not pull the rug on him. I told him he had 5 minutes; he took 12. But he was a little guy that looked mean, so I did not want to have a mad veteran.

[Laughter.]

Chairman ISAKSON. But there are too many of you all to do that. So you all are going to have to adhere to our 5-minute rule, or I am going to have to rap the gavel, not because I want to be rude but because we have got a lot to do, and we want everybody to get their fair time.

So, with that said, let me go to the Ranking Member of the Veterans Affairs' Committee in the United States House, the gentleman from Tennessee, Dr. Roe.

OPENING STATEMENT OF DR. ROE

Dr. ROE. Thank you, Mr. Chairman. I will be brief.

There are some special guests here. Any Tennesseans in the room? Anybody here make it from Tennessee?

[No response.]

There are some special guests. Our TAPS kids are here, and I want them to stand up: Lizzy Yeagy [phonetic], Chris Friarson [phonetic], and Jonathan Langford [phonetic]. If you guys would stand up in the back. Let us give them a hand.

[Applause.]

Dr. ROE. Thank you all for being here.

In the last Congress—and I want to go very quickly over what we did in the last Congress and really turn the floor over to you all—as the Chairman had said, it was really a historic Congress as far as the VA was concerned.

We passed the Accountability and whistleblower protection bill. We passed the Forever GI bill. And I think one of the things that we all—I do not care whether you are a Senator or a Congressman—appeals reform was incredibly needed because we all saw ap-

peals that went out for disabilities for years, and many veterans died waiting on those appeals to get adjudicated.

About 3 weeks ago, we have gone live with the new appeals program. We hope that that stops that.

As the Chairman said, we passed a really transformative bill in the VA MISSION Act, and the Chairman is absolutely right. What this Congress wants is the veteran to get top-quality care wherever they receive it.

I just saw the President's ask in the budget, which is a 7.5 percent increase per year for the VA, which is really remarkable.

From the time I got here in 2009, the VA through its three components—the cemeteries, disability, and health care—it was \$97.5 billion. That number the President asked for this year was \$220 billion. So he has really kept his word to look after America's heroes.

The one last thing I want to say, a bill very near and dear to my heart, which we really have been working on for 10 years is the Blue Water Navy bill. We need to get that across the finish line.

The House passed it 382 to zero. The Chairman and Ranking Member on the Senate side worked very hard to get that bill done. I want to thank them for their help. We are going to bring it back again, and we are going to pass it in the House again. And I feel sure this time that the Senate will get that passed.

I appreciate all of you all, who you represent. I appreciate you being here, and I yield back my time.

Chairman ISAKSON. Thank you very much, Dr. Roe.

Until the other two members of the four corners, Mr. Takano and Mr. Tester, come, we will introduce them later on in the program because I want to go right to you all. You all are on time and ready, so we are going to go to you. That is the way the military does everything. There, the NCO there, this officers group, you and I are the NCOs, so we will get things done around here. That is the way it works in the military; it is the way it is going to work on this Committee.

Thank you all for being here, and we have for the audience knowledge—wait. I want to introduce Mr. Alvarado-Ramos.

Is that correct? Did I do that right? I mean madam. Madam Ramos. I am sorry if I said—

Mr. Washington from the Fleet Reserve Association.

Ms. Wenum, President of the Gold Star Wives of America.

God bless you, darling. You look great in that gold.

Dr. Zampieri, National President of the Blinded Veterans Association, and I met you earlier. Thank you for being here today, and the information you gave me, I appreciate it very much.

Dr. Schneider, Commander of the Jewish War Veterans.

Mr. Greenlaw, Commander of the Military Order of the Purple Heart. Thank you, sir. It is an honor to be with you.

And Ms. Campos, Senior Director of the Military Officers Association of America. Thank you, ma'am, for being here.

So I am going to go directly to each one of you to make your statement, and then we will do questions. Keep it strictly to 5 minutes, please, because time is of the essence in this. We will start with Ms. Alvarado-Ramos.

STATEMENT OF ALFIE ALVARADO-RAMOS

Ms. ALVARADO-RAMOS. Chairman Isakson, members of the Joint Committee, my name is Lourdes, or Alfie, Alvarado-Ramos, president of the National Association of State Directors of Veterans Affairs, NASDVA. I am also the director of the Washington State Department of Veterans Affairs.

NASDVA is comprised of the Veterans Affairs' chief executives in all 50 States, the District of Columbia, America Samoa, Guam, Mariana Islands, Virgin Islands, and the Commonwealth of Puerto Rico.

We are the single organization outside of VA that represents the Nation's 19 million veterans, contributing more than \$10 billion annually in services to veterans and their families.

VA Secretary Wilkie and I signed a memorandum of agreement on behalf of both organizations last month. It outlines our partnership in direct services to our veterans and their families. We fully intend to exercise that agreement in order to address many of the recommendations made in our written testimony.

I would like to highlight a few of those. NASDVA fully supports efforts to increase veterans' access to health care under the MISSION Act. We do not support wholesale privatization.

Also, to meet the demands of the 21st century veteran, we are prepared to assist the VA with the electronic health record modernization. Failure is not an option for this multibillion project. The States are positioned to educate, promote, and provide VA with timely feedback for the success of this mission.

We recommend and will be working with VA on the following. First, for suicide prevention and awareness, we want to create outreach block grants to States to address shortfalls and improvements on suicide prevention outreach. States are in a better position and closer to the vulnerable veterans who need help.

Second, to properly serve the growing population of women veterans, the planning, renovating, and staffing of women veterans' clinics needs to be consistent across the country, which right now it is not.

Third, for Veteran Treatment Courts, we recommend increased multiyear funding grants to aid judicial districts in the establishment and sustainment of this life-changing program.

Fourth, following catastrophic events such as the hurricanes in Puerto Rico and the Virgin Islands, VA needs to establish provisions to care for all veterans in VA facilities, regardless of service connection.

Fifth, we along with the National Association of State Veterans Homes recommend two critical additions to the VA Veterans Home Per Diem Grant program. First, VA needs to evaluate the implementation of a new assisted living level of care to serve veterans unable to thrive at home, and second, to operate critically needed psychiatric beds, we recommend an increase in the per diem reimbursement that reflects the intensity of the staffing that they require.

Six, for the 2020 budget, we recommend the following levels of funding for the two large grants programs that impact the States—Veterans Home Construction Grant from \$90 million—that is the

recommended—to \$250 million and the Cemetery Construction Grant from 45- to \$50 million.

Other areas of consideration are increasing outreach to rural Native American and Alaska Native veterans. Next, revisiting the State approving authority agencies total requirement allocation model to ensure States have the resources to adequately apply auditing standards, and this is for GI Bill implementation. Resolving the Department of Labor's resistance to governors appointing their agency of choice to administer the Department of Labor Vets Grant program, and also, we urge Congress to intervene with the Department of Commerce to obtain veteran information the 2020 Census short form.

Finally, the emotional, physical, economic wellness of the families is paramount to veterans' quality of life. NASDVA recognizes the critical role families play in the veteran life cycle. We have spent billions of dollars to provide care to our veterans, but if the family is not well, then the veteran reaching his or her maximum potential will be compromised, resulting in the waste of precious resources.

We not only support but are in a great position to work with Congress, VA, other Federal and State agencies to ensure that veterans' families receive counseling, employment opportunities, and other safety nets.

Mr. Chairman and members of the Committee, thank you for your work on behalf of our Nation's veterans and their families and for including the National Association of State Directors of Veterans Affairs in this hearing.

Chairman ISAKSON. Very well. I paid close attention. She only went 7 seconds over. She deserves a round of applause.

[Applause.]

Chairman ISAKSON. Anybody that exceeds that is going to have to sit in this penalty box somewhere later in the morning.

[Laughter.]

Chairman ISAKSON. Great job, Ms. Alvarado-Ramos. We appreciate it very much.

Ms. ALVARADO-RAMOS. Thank you, sir.

Chairman ISAKSON. Mr. Robert Washington, national president, Fleet Reserve Association.

STATEMENT OF ROBERT WASHINGTON SR.

Mr. WASHINGTON. Chairman Takano, Chairman Isakson, Ranking Members, and members of the Committee, good morning. My name is Robert Washington. I am national president for the Fleet Reserve Association and the first African American to hold this position.

Behind me is Donna Jansky, a Navy veteran also, and she is the first woman national vice president of the association.

I am a retired Navy senior chief, having served for over 26 years in Naval service. I am honored to represent the concerns of the oldest sea service association that has been around for over 94 years.

Today, many issues are at hand. I will address our top five in the time allotted and their relevance to the FRA. They are Blue Water Navy, VA claims filing and backlog, Choice program, veterans suicide, and women veterans' health.

We, like you, are deeply troubled by the continued lack of passage of the Blue Water Navy Vietnam Veterans Act of 2017.

We sincerely thank Representative Phil Roe and Mark Takano for their tenacity and leadership in last year's House vote of 382 to zero. However, sadly, the Senate did not.

FRA deeply appreciates the House Chairmen and Ranking Members' quick reintroduction of the same bill in the 116th Congress.

Past VA policies permitted servicemembers to file claims if awarded the Vietnam Service Medal or the Vietnam Campaign Medal. However, in 2001, the VA implemented a boots-on-the-ground determination, which continues to limit the Agent Orange presumption allowance for the veterans who serve on ships off the coastal waters of Vietnam. It is still unclear from recent court litigation where the next step will be for Blue Water Navy veterans.

A recent modification introduced by Chairman Takano is a positive motion forward on behalf of these veterans. These initiatives strengthen continued awareness for eligibility status for the service-related VA medical and disability benefits.

Mr. Chairman, the VA Secretary, under his authority, has always had the authority to make this happen; however, still has not elected to do so.

Today, many of these veterans are senior citizens and can continue to hope for the earned benefit from those presumptive measures. Sadly, many will never have the choice to claim because they have already passed away or choose suicide as a result to ease their pain.

FRA concurs with the President's recently announced initiative on this epidemic. FRA appreciates the efforts of both Committees to meet the challenges of the VA Choice program. The Choice program is the capstone model for our veterans health care. Agreeably, it will require measurable oversight to accomplish the desired effectiveness.

FRA is especially thankful to the Congress for expanding the VA caregiver program to include all catastrophically disabled veterans.

FRA continues to be deeply agitated over our veterans' suicide rate. Recent suspended spending measures taken on by the VA clearly demonstrates a lack of comfort in decreasing these destructive behaviors.

FRA applauds Chairman Mark Takano's aggressive action of a new but a well overdue congressional task force in addressing women and veterans' health care.

The association greatly supports the needed gender-specific medical and mental health access that will also require--is also unique to the needs of women servicemembers and transitioning veterans.

Many women feel challenged going into a VA facility because of a climate of vulnerability that could enhance already associated anxieties, physical and emotional traumas from military, sexual trauma, and PTSD.

FRA looks forward to working with the Committee and the task force to help women veterans, especially with our growing female membership and future leaders.

On a positive note, the VA is making progress in the disability claims backlog but has a long way to go. The backlog may be down; however, appeals have spiked. FRA supports the Express Appeals

Act passed in 2017 to speed up the appeals process that remains way too long. We hope bill passage will reduce the waiting times. Someone once said justice delayed is justice denied. That also holds true for disability claims.

In closing, Chairmen Takano and Isakson, Ranking Members, and Committee members, all of these concerns should not add to the frustration of veterans. We thank you again for your leadership and direction on behalf of veterans and await your questions and comments.

Chairman ISAKSON. Well, thank you very much, and before we go to the next speaker, just so everybody else knows this, on the Blue Water Navy question, Chairman Roe and Chairman Takano did a fantastic job in the House, did a fantastic job.

The Senate, in the end, rallied. We got within two votes of getting it out of the Senate. We only had two objections, but we did have two objections. I think those objections are working their way off. The decision by the courts was 9 to 2. Whether or not the VA appeals that decision is yet to be known, and I am told—this is no authoritative statement whatsoever. Nobody can write or quote me on this, this thing is going to happen, but it is very difficult to see that being overturned, a 9-to-2 margin being that strong.

That being the case, I think the Blue Water Navy will in fact get done this year. I do not see a major obstacle in terms of members of the Senate to cause something to happen. It could turn. Something could change, but the way we finished last year, I think that is the way it will be.

And I appreciate you bringing that up, and I want to let everybody know the same thing so we do not have to waste some of your time on redoing another subject one more time. With that said, Crystal Lynn Wenum, welcome.

STATEMENT OF CRYSTAL LYNN WENUM

Ms. WENUM. Chairman Isakson, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and distinguished members of both the Senate and House Committees on Veterans' Affairs, I am pleased to be here today to testify on behalf of the Gold Star Wives of America to share our legislative priorities.

My name is Crystal Wenum, and I am the widow of Staff Sergeant James O. Wenum, a Vietnam veteran who served during the Tet Offensive. He died on May 8, 1982, leaving me to raise 5- and 3-year-old children. His death was determined to be service-related 2 years later, and I joined Gold Star Wives that year.

But in addition to being a Gold Star Wife, I am also a Gold Star Daughter. My father was killed in action at the Chosin Reservoir in Korea on November 29, 1950. My mother was 6 months pregnant with me and had a 1-year old son at the time. My mother joined Gold Star Wives in 1951, and I have literally grown up with this wonderful organization. I have remained active with Gold Star Wives, and I am proud to now be its national president.

Gold Star Wives is grateful for all the public laws that have been passed in the years since 1946. These laws provide much needed benefits for surviving spouses and children of our military service members.

My testimony today will be addressing some of the inequities and concerns that currently exist.

Dependency and indemnity compensation. “To care for him who have borne the battle and for his widow and orphan.” These words from Abraham Lincoln’s Second Inaugural Address in 1865 succinctly state the sacred promise our country has made to our veterans and survivors.

The VA stated in September 2018 that there are 394,028 surviving spouses who receive DIC. The flat monthly rate has not been increased except for cost-of-living adjustments, since 1993. When DIC is compared to payments to surviving spouses of other Federal employees, DIC lags behind 12 percent. The other Federal survivor benefit plans pay a surviving spouse 55 percent of the spouse’s salary.

We are looking forward to the introduction of bills in the Senate and House to increase the DIC from 43 percent to 55 percent, which would bring parity with other parity with other Federal survivor programs.

Survivor Benefit Plan/Dependency Indemnity Compensation offset. In 1972, Congress created the Survivor Benefit Plan for retiring servicemembers who may select up to 55 percent of their retirement pay towards SBP.

The average monthly DIC offset to SBP is \$915. The spouses subject to the SBP/DIC offset only receive the portion of the SBP that exceeds the DIC offset.

A bill, H.R.553, Military Surviving Spouses Equity Act, was introduced in the House by Representative Wilson and Representative Yarmuth. There is a companion bill, Senate 622, Military Widow’s Tax Elimination Act of 2019, of 2019 in the Senate. This one was introduced in a bipartisan effort by Senator Jones, Senator Collins, Senator Tester, and Senator Crapo. Both bills will repeal the SBP/DIC offset and eliminate the inequity.

Eliminate the Remarriage Penalty for Young Surviving Spouses. GSW would like your assistance in changing current law that binds young surviving spouses to widowhood. Under current law, if the surviving spouse remarries before the age of 57, he/she forfeits life-saving benefits afforded to them. GSW has realized age 57 is an arbitrary age that penalizes young surviving spouses.

H.R.95 and Senate 91, the Homeless Veterans’ Children Acts, would allow per diem payments to be extended to homeless veterans’ children under comprehensive service programs. GSW supports these bills and hopes that Congress will pass them in a timely manner so that homeless veterans’ children can be taken care of in the same manner as the veteran.

Being intimately familiar with the devastating of death, GSW is extremely concerned with the overwhelming number of veterans and active-duty servicemembers who die by suicide every day. GSW supports any effort to reduce the rate of service-connected deaths by suicide.

In conclusion, Gold Star Wives of America is appreciative for existing laws that provide vital benefits and support for surviving spouses and children of our military members who gave their lives for our country.

President John F. Kennedy said, "A nation reveals itself not only by the citizens it produces, but also by the citizens it honors, the citizens that remember."

Again, thank you for the opportunity to testify on behalf of Gold Star Wives of America. I am available for any questions.

Chairman ISAKSON. Well, Crystal Lynn, before I turn it over to the next speaker, let me just say this. I love Senator Kennedy's quote, but we also as a country are distinguished by the wives and spouses of those soldiers who go to battle, those who make home for them, those who when they come home love them, and when they do not come home, honor them and cherish them like you have.

Your double sacrifice is recognized, and we are all very sorry for it. But we are very proud of your service, the service you render on behalf of Gold Star Wives and Gold Star Mothers all over the country.

We thank you for being here today, and we thank you for your sacrifice for your country.

Ms. WENUM. Thank you.

[Applause.]

Chairman ISAKSON. Dr. Thomas Zampieri. "Zampieri," is that right?

Mr. ZAMPIERI. Yes, sir.

Chairman ISAKSON. Close enough, anyway.

Mr. ZAMPIERI. Close enough.

[Laughter.]

Chairman ISAKSON. Welcome, sir.

STATEMENT OF THOMAS ZAMPIERI

Mr. ZAMPIERI. On behalf of the Blinded Veterans Association, we appreciate the invitation to speak today before Chairman Isakson and Chairman Takano, Ranking Members Tester and Roe. Some of you are old friends, and we always enjoy our engagement with the members. And I welcome the new members here.

We have been the Blinded Veterans Association 74 years come March 28th, and we are very proud of our tradition of working with the VA and with Members of Congress.

Some five issues that I wanted to cover in the time that I have, one is that--and we appreciate that when you passed the MISSION Act, you included caregivers for the pre-9/11 veterans, and we are frustrated, though, because of the fact that as they work out the details for the caregivers support program for previous generations of our war-blinded veterans, first of all, the length of time, that we are told that it could take another year, we have got our immediate past president, who is a Vietnam veteran, who is blind, and he is on home dialysis. And his wife has health problems, and she is literally trying to take care of him.

It is so frustrating. He has not just waited a year for implementation of this. I say he has waited 45 years for caregiver support.

So, as you hold hearings and do oversight with the VA with the caregivers program, I certainly hope that you will ask witnesses questions about their timeline and then are they going to include catastrophically disabled veterans in their benefits.

The other thing is we have worked with the VA consistently on trying to get them to make the IT systems accessible, Sections 508 and 504. Many of the members of the Committee are familiar with this.

We are especially concerned that as they roll out with this new Cerner contract and the electronic health records, that is another chance that they will implement, yet again, another new program with their IT system that will not be accessible for blind veterans.

So, as you have different witnesses coming over from that VA, I appreciate Chairman Roe—Ranking Member Roe and his persistence with the VA about making sure that things are accessible.

Both the Veterans Benefits Administration and VHA, they really have to fix a lot of the stuff that they have had problems with in the past.

Touching on a little bit of a different topic, which is Vision Research Program within the Department of Defense, for the House Members here, I know Friday is the deadline for your views and estimates. We are asking all the members of the House and Senate to request that the Appropriations Committees include \$20 million for a vision trauma research program within the Department of Defense. It is the only place in the entire country where there is money for battlefield eye-trauma research.

NIH does not do it. The VA does not do eye-trauma research. The only funding comes through DoD, and so when the Boston Marathon blast occurred or when the blast occurred up in Manchester, England, you go around the globe nowadays, and there is eye trauma from blasts. It is the research that DoD is doing that is helping our civilian trauma hospitals also and how they deal with these horrific eye injuries.

The other thing is we have been working with the VA on trying to get them to include local transportation for blind veterans. It is a temporary program. Congress has to reauthorize it every year.

Special mode transportation. The VA has sort of struggled with that. Different departments have said that you have to be wheel-chair-bound before they will send a van out to pick you up. Special mode transportation, I would argue should be for any catastrophically disabled veteran that needs transportation to get to their medical appointments.

We would like you to make the transportation program permanent, but also to ensure that the VA's policies include that blinded veterans be eligible.

The Special Adaptive Housing grant, unfortunately, my friend, Senator Boozman left, but he and I worked when I was director of Government Relations on legislation for this adaptive housing grant program. That needs to be fixed because it currently requires you go have no vision in order to be eligible for the SAH.

Those are the five things I wanted to cover. I appreciate your time and look forward to any questions you have.

Chairman ISAKSON. Thank you for your testimony, your service, and your sacrifice. We appreciate it very, very much.

Dr. Schneider.

STATEMENT OF BARRY J . SCHNEIDER

Mr. SCHNEIDER. Good morning, Chairman Takano, Chairman Isakson, honorable members of the Committee. My name is Dr. Barry Schneider. I am an Air Force career officer and the national commander of the Jewish War Veterans of the United States. Jewish War Veterans will celebrate its 123rd anniversary this coming Friday.

The Jewish War Veterans of the USA acknowledge and appreciate the effort taken to reduce and prevent the current reported rate of 20 veteran suicides per day. Veterans are one and a half times more likely to commit suicide than nonveterans. More than 6,000 veterans take their lives each year.

I hope the new Cabinet-level task force initiated by President Trump last week to prevent veteran suicides will be successful.

Suicides, as a public health issue, affects everyone-- families, friends, and community. With the resources of this Committee, the VA, and Congress, a plan can be, and should be, devised to address this crisis in a meaningful and successful manner.

More must be done. JWV urges the full mental health screening using all available assessment tools and full access to veteran facilities for all individuals exiting the military.

As a lifelong educator and student, the issue of student veterans resonates with me in a very personal way. I have earned two master's degrees with significant assistance from Federal and DoD programs. I am pleased that the post-9/11 GI bill provides significant benefits and provides a positive path for returning veterans to re-enter society as productive citizens.

On behalf of JWV, we thank you for recognizing the importance of this bill and ensuring its continued funding. However, since the post-9/11 bill became law, many for-profit predatory colleges have sprung up, and they view our veterans as nothing more than dollar signs.

There are many reports of aggressive and deceptive targeting of veteran servicemembers and their families. They engage in misleading recruiting practices on military installations and often fail to disclose meaningful information enabling potential students to determine if a college has a good record of graduating and positioning students for success in the workforce.

As I have traveled around the country and visited many colleges and universities, I have found great differences among the various institutions. The schools which have excelled have one thing in common. They provide one-stop shopping for our veterans and their families.

For example, the University of Colorado Boulder has established an office of Veteran and Military Affairs, VMA. This office is staffed by veterans for veterans. They operate from their own building and provide transitional support to higher education and civilian life.

The unique circumstances of veteran students moving from the military environment to academia requires special support. The University of Colorado's VMA office provides this in an exemplary way. This includes a Bridge Summer program and their Veterans Ambassador program, which helps new students connect with other veterans prior to the beginning of the school year.

The VMA office provides both academic and life counseling, tutoring, hands-on assistance, and applying for various VA benefits and financial supports.

To ensure that all of our veterans receive this level of support, JWV asked the Department of Veterans Affairs and Congress to establish a rating system ensuring that all educational institutions that receive Government funding meet at least minimum requirements and standards of accountability to ensure that our veterans can select with confidence a program which will meet their needs.

From my perspective, accountability must include single point of contract, proper accreditation, staffing by veterans, readily available access to counselors for academic and financial advice, and a sense of community where veterans can meet with other veterans to openly discuss problems and issues that they face during their transition.

Further, a list of acceptable institutions must be made available on the VA website.

Predatory institutions which take advantage of our veterans and their families must be stopped. The post-9/11 GI bill is a great benefit, and Congress must ensure its proper administration.

These simple actions will ensure that our veterans have the greatest chance of success and that the Government receives the best return on their investment.

I thank you for your time and attention.

Chairman ISAKSON. Thank you, Dr. Schneider. We appreciate it very much.

Mr. Greenlaw, the Military Order of the Purple Heart National Commander, we welcome you.

STATEMENT OF DOUGLAS J. GREENLAW

Mr. GREENLAW. Thank you, sir.

Douglas J. Greenlaw, former First Lieutenant, 05332162, U.S. Army.

You are part of the leadership of our Country, and I stand before you as a very proud individual. Thank you for all that you do.

Earlier, I placed my formal words into the permanent record as National Commander of the Military Order of the Purple Heart. I would like to dedicate my precious time today by speaking directly to you up close and personal about our Country's combat-wounded veterans.

I speak in behalf of the 500,000 Purple Heart recipients in America that were wounded in protecting our beautiful country in combat, and of course, we respect those that died in the form of their duty as well. We give them special recognition of their sacrifices.

But, today, I would like to call about the combat-wounded vets, the survivors, those that have been spared death but have had the unfortunate case of being wounded, some gravely wounded. They live with the physical and the mental trauma that affects not only the body but the mind, sometimes even the soul.

As a recipient of two Purple Hearts in Vietnam, I was wounded gravely the second time, but I consider myself fortunate because my scars lie beneath my clothing. Not all were so lucky.

I know a patriot who woke up in a zipped-up body bag in the cooler, and that is only half the story. As he struggled in that bag,

he had a religious experience. God visited him in that bag as he struggled, and to this day, he feels that he was told by God that Jesus never died. Jesus woke up in that tomb, just like he did, and he busted his way out. He showed his wounds to his friends, and he married Mary Magdalene, had a wife, children, lived a life.

My pastor told me that that is a common theory called the “swoon theory.” Well, it is no theory to the man in the bag. You will never convince him of otherwise.

Charles Eggleston, a good friend of mine, was gravely wounded in an IED explosion and following mortar attack behind him. He suffered massive wounds. He was in the hospital for 3 and-a-half years—3 and-a-half years.

The surgeons were taking bones out of his back from the men blown up behind him. To this day, he has shards of bones in his body that he carries on a daily basis. Try living with that. It is called PTSD.

Bob Bostwick, another friend, was wounded and captured, POW in the Korean War. As the Chinese who captured him dragged him overland to their hidden camp, they beat him focusing on his wounds, telling him they were going to torture, interrogate, and kill him. He thought, well, if they are going to kill me, they are going to kill me escaping. In the dark of the night that night, wounded and weak—he was a pretty strong guy—he overpowered—he killed his guards, two guards. He escaped somehow, weakened, finally found himself to find his way back to his unit in South Korea.

Now, here is my point. Do you know how old this gentleman was when he experienced this? He was 18 years old—18, right out of high school.

We are not fighting wars with 40-year-old Harvard MBAs. These are our young warriors that are out there, 18, 19 years old. I was the old man. I was the old man at 23 as an infantry company commander in Vietnam, fighting and leading 158 men in the swamps and valleys and rivers and mountains of Vietnam.

May I please say just a couple of words about our young military today, the millennials. They are a fine generation of Americans. Every military generation is better than the one before. Today, they are bigger. They are stronger. They are better equipped. They have the same patriotism than the veterans that fought before them. So if you see one, he is 18 years old, treat him like an adult or her like an adult because that is what they are.

I could go on and on with stories, but I know my time is limited.

When legislation crosses your desk, please remember us, the combat wounded, the Purple Heart recipients.

The laws on paper represent real men and real women from all wars, and your support is so important. If you remember anything I say today, please remember this. Our bodies heal, but our scars remain, and our wars never end.

Thank you.

Chairman ISAKSON. Mr. Greenlaw, thank you very much.

And let me just comment, if I might, for 1 minute. Your testimony is very compelling. We are all aware of the sacrifice but sometimes not as aware of the depth of the sacrifice of an individual as you point in the stories that you told.

We know what the Purple Heart means. It means you were wounded in battle. I did not know until you told me there were 500,000 Purple Heart recipients. Is that the right number?

Mr. GREENLAW. There is no exact number, but that is the estimate.

Chairman ISAKSON. That is how many people took a bullet for us, basically to say.

One other thing I want to underline is that the injuries of the wars of the 21st century are different from the injuries of any other war we have ever had, and so many of them are soft-tissue injuries of the brain of the psyche, and of the soul. It is very important that you point that out. We should never forget anyone, and we should always remember there is a tragic story behind every veteran. Sometimes they hide it all their life from us, but they go through it every day because they were the ones that experienced it.

Thank you for your testimony today. We appreciate it. Ms. Campos.

STATEMENT OF RENÉ A. CAMPOS

Ms. CAMPOS. Chairman Isakson, Ranking Members Tester and Roe, and members of the Committees, I would like to take this opportunity to ask our MOAA members in the audience to stand and give our appreciation and round of applause for making the 115th Congress one of the most successful in recent years and for this opportunity to testify.

[Applause.]

Ms. CAMPOS. I will start by leaving you with three important messages. First, there is no higher priority for veterans than to ensure the Secretary and his staff have the tools and the time they need to succeed.

We must also keep our eyes on the impact of these reforms on veterans. One MOAA female veteran from Montana questions the new VA legislation and will it leads to real improvement. She says, "I have been in the VA since 1994 with great success until recently. In the past 2 years, I have been assigned five different medical providers because the VA cannot keep the doctors. I am a cancer survivor who is not considered cured. I have had three different tests to keep everything in check. None of these tests have been reviewed with me."

Second, there needs to be more collaboration between the VA and the DoD to include hearings—between the Veterans and the Armed Services Committees on important issues such as toxic exposure, women veterans, the electronic health record, and mental health and suicide prevention, shifting more responsible back to DoD as an employer for addressing outcomes for transitioning servicemembers to veterans status.

I will touch on three priorities from our statements. The first one is CHAMPVA. When ACA became law, it required health insurance plans to provide dependent coverage of children, including coverage for an adult child to age 26. Private-sector and DoD health care plans confirm to the law. MOAA urges the Congress to expand this care to CHAMPVA.

Then, finally, in the area of behavioral health and well-being, there is no doubt VA has made great strides in expanding its

health care services to help veterans suffering from pain, traumatic injuries, and mental health. VA cannot let up its efforts because the need is so great.

MOAA recommends investing in VA and DoD collaboration and services and investing in ways we can identify at-risk populations.

Then in the area of women veterans, VA continues to struggle to adapt to meet the rising demand in delivering needed health care and disability benefits to the women veterans. For nearly 4 years, MOAA has partnered with the United Health Foundation, studying how the unique demands of military service affect the long-term health.

We have produced three reports—two on a broad group of those who have served and a narrow report on women veterans.

Last year's Health of Those Who Have Served Report revealed those who served are more likely to describe their health better than their civilian counterparts, but they are also more likely to suffer from a litany of chronic diseases and to engage in unhealthy behaviors.

The study also showed some troubling trends, particularly among women veterans whose rates of suicide thoughts more than tripled between 2011 and 2016.

MOAA is grateful to the Committees for your commitment to ensuring women veterans have equal access to medical and other benefits. The important work you did in the last Congress combined with Chairman Takano's and Representative Brownley's efforts in establishing a women's task force provide the needed momentum to make significant progress this year on these issues.

In closing, I would like to share a story of an active-duty Army servicemember and his father's care in the VA and how it formed his perception of the VA.

Just before retirement, his father received a letter from VA notifying him of the abnormally high rate of veterans in Desert Storm and Desert Shield in his unit with brain-related issues. VA later denied his father's claim because he could not prove service connection. He died at age 56 of brain cancer.

Before his father's death, his son was told VA had no hospice program for veterans under 65. It took the director of the Indianapolis VA to finally authorize hospice care.

This servicemember's takeaway, while the VA providers, the staff, and the health care were awesome, the lag time between discharge from service and VA care and the bureaucracy continues.

This story speaks to the generational consequences of how we treat and care for our veterans. I know I want my son, who is in the military now, to be able to have the same trust and confidence in his VA when he leaves service as I have experience from my service.

MOAA is committed to working with the Committees and the Department to help build a VA all veterans can be proud to call their own.

Thank you again, and I look forward to your questions.

Chairman ISAKSON. Thank you, Ms. Campos, and I am now going to turn the gavel over to Mr. Takano, the House Chairman, to complete the hearing this morning.

I want to thank all of you for your participation and all the members for being here.

Mr. Takano, I will turn it over to you. Thank you, sir.

OPENING STATEMENT OF CHAIRMAN TAKANO

Chairman TAKANO. Yes. Thank you, Chairman Isakson. It is always an honor to join you and Ranking Members Tester and Roe and all members of the House and Senate Committees on Veterans' Affairs to hear directly from the organizations that represent millions of veterans and their families who are impacted by our decisions. Like the rest of the members sitting at the dais, I take this responsibility very seriously.

First, I want to welcome our partners from the National Association of State Directors of Veterans Affairs, the Fleet Reserve Association, Gold Star Wives of America, Blinded Veterans Association, Jewish War Veterans, Military Order of the Purple Heart, and Military Officers Association of America.

I would also like to specifically recognize members from my home State of California. If there are any Californians here, just kind of wave.

[No response.]

I do not see anybody waving. That is kind of surprising.

[Laughter.]

Chairman TAKANO. But welcome, wherever you are from.

Mr. ROE. It is a small State.

Chairman TAKANO. That is right. Dr. Roe says it is a very small State.

[Laughter.]

Chairman TAKANO. I am thankful for the opportunity to hear from our VSO partners, many of whom are veterans themselves. Each of you represent a unique group of veterans and surviving spouses, and because of that, each of you possesses a unique set of concerns.

The joint hearings provide us with a unique opportunity to hear the focused messages from so many of our VSO partners who do the work every day to help our Nation's heroes. Congress simply could not deliver on our promises without the dedication and first-hand understanding of the issues that affect our servicemembers, veterans, and their families. So thank you all for what you all do.

With your help, we have identified many problems and fixes to those problems, but the work is far from over. Your continued input as we move through the 116th Congress is not only needed, it is truly appreciated. I ask that you continue to hold the administration and Congress accountable and ensure both fulfill our Nation's promise to care for our veterans. If we can afford to send our people to war to protect our country, then this country can and must afford to take care of our wounded when they return.

Reading through your testimony, your concerns, I want to just say this. Your concerns are my concerns and the concerns of the House Veterans' Affairs Committee. The message from you and your VSO cohorts is clear. Congress must keep a vigilant eye on the VA and pass legislation to care for our veterans.

Mental health, eliminating veteran suicide, ensuring equal access to quality medical care for all veterans, regardless of gender or dis-

ability, and to ensure that access to crucial VA services be available to veterans of all eras should be our priorities.

Outreach and care for women and minority veterans must also be addressed in this Congress, and I am pleased that attention for these veterans' groups continues to rise.

And I am glad that the testimony of the National Association of State Directors of Veterans Affairs highlights aspects of access hurdles our Native American veterans face.

I want to make it clear to you today that I directed my staff in January of this year to better understand the hurdles that Native American veterans face in attaining earned VA disability benefits, and I plan to identify and implement solutions that will improve the lives of our Native veterans and all underrepresented veterans in my time as Chairman of the House Veterans' Affairs Committee.

While I just touch on a few issue areas important to you and your membership, know that I am committed to helping advance your priorities in the coming year.

I look forward to hearing your testimony today and thank you again for your tireless advocacy on behalf of our veteran community.

So I am going to yield back to myself the remainder of the time.

With that, I think we just move on to the——

Senator TESTER. I have an opening statement.

Chairman TAKANO. Oh, you have an opening statement.

I now want to recognize Senator Tester, the Ranking Member of the Senate Veterans' Affairs Committee, for his opening statement.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Thank you, Chairman Takano, and I will be very brief.

First of all, thank you all for your testimony. I very much appreciate the input that all of you have given us. As I have said before, we take our cues from the veterans service organizations and the veterans that are on the ground when it comes to making policy and hold the people accountable that that policy be carried out in an appropriate way.

I do want to respond very quickly to Mr. Campos' comments about a woman veteran from Montana that has since 1996 seen five providers in the last few years. This is a problem. It is a huge problem in Montana where we went through, I think, eight directors in the last 12 years, and we cannot keep employees. Somebody is trying to privatize Montana's VA.

It has gotten to the point now where when veterans call in, they immediately put them into the private sector, at least in some cases, without even offering them VA health care. That, in my opinion, is ridiculous. We have got to find out what is going on.

And, as we move forward and as we do things like pass the MISSION Act and pass the Accountability Act and pass the appeals backlog and the Forever GI bill that we did last Congress, we have got to make sure things are improving and not going the other direction.

There are some who want to privatize the VA. Hopefully, none of them are on this rostrum. They have said time and time again, they are not, but the bottom line is if you do not have docs—and

that is what we are seeing in Montana--you have privatized the VA.

So thank you all very much for your input. We look forward to our questions.

Thank you, Mr. Chairman.

Chairman TAKANO. Thank you, Senator.

Now we will move on to 5-minute questioning. Are we doing 5 minutes or 3 minutes? We are doing 5 minutes.

I would like to first recognize Representative Sablan from the Northern Mariana Islands for 5 minutes.

REPRESENTATIVE GREGORIO KILILI CAMACHO SABLÁN

Mr. SABLÁN. Good morning, everyone, and to our witnesses and to everyone in the room, thank you very much for joining us today.

My favorite part of being in this Committee is to have conversations and listen to both veterans but particularly the veterans service organizations. Thank you very much for all that you do for our veterans.

I come from a place where the only place in the United States that does not even have a CBOC. We have one of the highest enlistment rates in the uniformed services per capita in the Nation, and yet our veterans come back and do not have the services that they need.

But let that go for a while. I would like to ask the witnesses at least to please raise your right hand if you support the privatization of the Veterans Administration.

[No response.]

Anyone who supports the privatization of VA?

[No response.]

Thank you, because neither do I.

I think VA provides some of the best service for our veterans. We only need to continue working to improve those services.

And, Mr. Chairman, thank you, and I yield back my time.

Chairman TAKANO. The gentleman yields back.

I call upon Dr. Roe for 5 minutes.

Dr. ROE. Thank you, Mr. Chairman, and I want to thank all the members for being here and your incredibly compelling testimony.

Dr. Schneider, you do not look 123. I am going to say that for you.

Mr. SCHNEIDER. I am pushing it.

[Laughter.]

Dr. ROE. Tom, thank you for your comments.

Certainly, I think the vision research that you pointed out, the \$20 million, we have got to dig down and make sure that is there. If that is the only place that is occurring, that has to stay there. I totally agree with that.

The transportation, I took several notes on what you would like to see done. Those are all, I think, incredibly reasonable things to do.

Mr. Washington, I want to thank you for your eloquent comments about the Blue Water Navy. We have to get this right, this Congress. For 10 years, we have been working on this, and you have been working on it probably for 30. And I thank you for that and your support.

All the VSOs have been incredibly supportive of this, and we plan, I know with the Chairman's help, to get this through.

Ms. Campos, you mentioned something that is very near and dear to my heart. You cannot have continuity of care if you see five different doctors all the time, and I would respectfully disagree with my good friend, Senator Tester.

The problem we are having in this country, we do not have enough providers. Getting those providers to go in rural areas is a challenge.

I know I saw when the VA at home did not have an OB--I am an OB/GYN specialist. When they did not have that, I saw that as their extender. I was their OB/GYN department, our group was.

So I think what we have to do—and we are getting market assessments across the country to find out what resources are available in each community in the country, and then that is when the Choice program is set up where it is. If the VA cannot provide that service, then it is provided outside the VA.

I have said this a thousand times. If we have gone in my 10 years here, we have over doubled the VA budget, that is not privatization. I think everybody up here believes that.

I think we have got a huge challenge about how to get providers, and this current budget the President asked for was to increase the number of employees to 392,000. That is larger than the U.S. Navy. So we are doing I think what is right for our veterans.

Implementation, as everybody has said, is absolute key, and certainly implementation of the MISSION Act, which is the most transformative bill I think we have passed in VA since I have been here.

What hurdles do you all see in the VA MISSION Act? It goes live the 6th of June. Anyone can take that question. Biggest hurdle for the MISSION Act.

Ms. CAMPOS. I will take that question, sir.

I think the biggest question is how will it be implemented across the system in a uniform consistent way, in a way that it can be explained to veterans, VA employees, that they will understand and be able to know if they are eligible right up front.

So I think that there is a lot of challenges about we can look at quality. We can look at the access standards. Those are arbitrary.

I think that we are still going to have problems as this is rolled out. There has not been a lot of communication.

I know we have asked, with our other VSO colleagues, for more information from VA to get out to veterans, so they can understand what this means.

I went to a Tallahassee VA not too long ago, and they are getting confused between the Choice program. Some people think that the MISSION Act and the Community Care has already been rolled out. So there is a lot of confusion out there, and I think that if we do not get ahead of the communication on this in the front end with the employees to be able to talk to veterans about those and to the providers, that those veterans are going to be talking to, as I said, across from their provider trying to decide where is the best place to get their care.

Dr. ROE. I think several of us are having—I think it is in the morning. We are having breakfast with the Secretary. We will ab-

solutely pass that along because I think the VA needs to include you guys, all the veterans service organizations, so you can educate your membership. I think that is a huge benefit.

Before I yield back, Captain Greenlaw, I want to thank you for your incredible service to this great country. I salute you, sir.

I yield back.

Chairman TAKANO. Thank you, Dr. Roe.

I recognize Senator Tester for 5 minutes.

Senator Tester. Yeah. Thank you, Mr. Chairman.

Just for the record, 12 year ago, we had one of the best VAs in Montana in the country. We had doctors. We have had a doctor shortage for some time. I have not had a doctor in my hometown in 30 years.

What has happened in Montana is there has not been appreciation for the doctors that have done the work, and they have been run out. They are waiting in the private sector to come back, but they have got to have a VA that wants them back. And we do not have that in Montana. I do not know if they have that in Tennessee or not, but they do not have it in Montana.

Quite frankly, it is a problem, and it is a big, big problem because our veterans deserve better than that. As the fellow from the Northern Mariana Islands asked, nobody wants to privatize the VA, and I certainly think the veterans prefer the VA over the private sector.

But I want to talk about mental health for a second because I think just about every one of you talked about mental health in some form or another.

It is a big problem. Tomorrow, I am going to introduce legislation that is going to do a couple things. It is going to strengthen support services for VA members who are transitioning from DoD to VA health care, that transition time. It is going to invest in innovative treatments for mental health conditions, different kind of treatments than we normally think about, somebody laying on a couch.

Well, there are other methods too—yoga, music, animal therapy, meditation, acupuncture. It is going to cut red tape for VA and vet centers to hire more mental health professionals. It is going to increase rural veterans' access to telehealth, which as we know oftentimes can be better than eyeball to eyeball if we utilize it. So not only does it work in rural areas, it works in urban areas too. And it is also going to increase accountability of the VA's mental health outreach and suicide prevention efforts.

Once again, we are going to work. We are going to work in a bipartisan way to get this bill passed. It has got to be implemented correctly if it is going to do what we want, but we all understand that mental health, which has been the signature injury coming out of the war for the last 20 years, is a big, big issue.

For anyone on the panel, in terms of the VA's current mental health and suicide prevention efforts, can you tell me where the VA is making the grade and where it is missing the mark? Is there anything that the VA is doing that is working?

Yes, go ahead, Mr. Greenlaw.

Mr. GREENLAW. In South Carolina, I am from the Greenville area, up in the northern part of the State. We have one of the finest VA clinics, probably in the country. It is only a few years old,

78,000 square feet. It runs like a clock. They handle about 850, 900 vets a day, and they do a fantastic job.

Senator TESTER. Marvelous. Good.

Mr. GREENLAW. So I think these clinics are the unsung heroes.

Senator TESTER. Yeah. Good.

Anybody else?

Ms. ALVARADO-RAMOS. Yes, Senator Tester.

Senator TESTER. Yes, ma'am.

Ms. ALVARADO-RAMOS. From the National Association of State Directors of Veterans Affairs, in Washington State particularly, we have significant collaboration from the State with a program that does behavioral health and the Federal VA.

The area where we have some challenges is with the vet centers—

Senator TESTER. Yes.

Ms. ALVARADO-RAMOS. —and the staffing.

Senator TESTER. Staffing of the vet centers?

Ms. ALVARADO-RAMOS. Exactly.

The vet center is such a hybridized system, such an amazing system to veterans and families that VA needs to fully staff those, and I think they are having some of the same issues regarding staffing—

Senator TESTER. Yes.

Ms. ALVARADO-RAMOS. —and them working for the Federal VA. But this is an area that when it comes to behavioral health and emotional wellness, there are critical services for our veterans and their families.

Senator TESTER. That is good input too.

Dr. Zampieri.

Mr. ZAMPIERI. Yes. I was just going to say the same thing about the vet centers.

Senator TESTER. Yes.

Mr. ZAMPIERI. Being a Vietnam-era veteran, the vet centers have been amazing, but telehealth, mental telehealth clinics, whether you are in a big city or a rural area, it is another way to make access ability easier for those veterans.

The crisis center, I applaud the VA for the work that they have done with the crisis center.

Ironically, though, by the way, the website was not accessible for blind veterans.

Senator TESTER. Yes.

Mr. ZAMPIERI. Yeah. That is one of those things that you just say to yourself, "How could that happen?"

But the last thing—and you have touched no it, and we have talked before—is the length of time it takes to hire someone in the VA, whether it is a physician assistant, a psychiatrist, a psychologist, a counselor. It takes—and I know. My wife works in the VA system. That will get her in trouble, but it takes months and months.

So you have a provider who comes and interviews.

Senator TESTER. Yes.

Mr. ZAMPIERI. They want the position, and 5 months later, they have not been brought in.

Senator TESTER. Bingo. Somebody else will hire them by then.

Mr. ZAMPIERI. Yeah.

Senator TESTER. Yes.

And, by the way, we have worked to try to cut that down, but that is something we need to also keep paying attention to, to cut that timeline down. There is not a doc out there worth his salt that is going to stick around past 2 months. Fact. It is a fact.

Thank you all for your input. Thank you all for your testimony. God bless you all.

Chairman TAKANO. I now call on Representative Bost of Illinois for 5 minutes.

REPRESENTATIVE MIKE BOST

Mr. BOST. Thank you, Chairman, and I want to thank all of you for your service. I want to thank you as veterans for your service and all of those that are out there that maybe are not veterans but are serving our veterans. I thank you so much for that.

Let me also say this last year, we—and in your input, each group and organization, that when we put in the Appeals Improvement and Modernization Act. Let me tell you that that is an issue that we have worked on, and without your help and input on that, we could not actually get it going.

But right now, the Secretary is getting ready to certify it. As your input helped that off the start to make sure we were taking care of our veterans and getting their appeals process speeded up, one of the main concerns I had was a legacy appeals.

I am just asking the whole panel, anyone that could have input on this, what do you see where they are at right now? Can you give me feedback on what the veterans are feeling right now, those that are sitting in a legacy appeals process? Are they feeling like they are speeding up? Is it still just laying out there?

Ms. CAMPOS. I will take that question. I think when we think of the legacy systems, we tend to think more on the Department of Defense side where people have been injured, and they have been put in temporary, limited duty status or—excuse me—in a retirement status, temporary retirement status.

Three years later, they come back. They may have gone through the joint disability evaluation system and were put into that retirement status, but then they have to come back and be reevaluated, and then they go through the legacy system on the DoD side. Then it is kind of viewed as they are going to be—their benefits are going to be decreased.

We believe that if they have already been in the integrated disability evaluation system, they should be able to go back through that process again before they are reviewed for final retirement status.

Mr. BOST. Many of these legacy appeals, we were afraid were going to linger out there. We were going to be able to hit the new appeals very quickly with the new system, but those that were old, that they could not get the reaction in time that the newer appeals processes were getting. And I do not know whether anybody is noticing that or not.

Ms. ALVARADO-RAMOS. I will say something about that. I was in an Honor Flight last October and having a conversation around the table with some of our veterans, the people that we were guardians

for. The conversation was, at that time, not around how long it took for their appeal to take place but comparing notes of how short a time it was taking. So I think there is progress being made by VA——

Mr. BOST. Okay.

Ms. ALVARADO-RAMOS. —when it comes to being able to expedite.

And I just wanted to say just one quick thing when it comes to the States because one of the things that the States can provide is extensions to the VA to be able to work on the claims backlogs and to be able to get more veterans connected to those appeals and to the new system, but part of that is on-the-ground services and States being able to get the ability through potential funding to expedite and be able to connect more veterans into the new systems.

Mr. BOST. Well, the concerns I had—and I am very short on time. You see, I myself, as a Marine veteran, whenever I left, I had lost my high-frequency hearing. My wife believes that it is just a selective hearing that I have.

[Laughter.]

Mr. BOST. But we did have that tested.

But it was at a time, at that time in the Marine Corps and the military—you are 23 years old and you want to go home. They ask you to sign a waiver, and then you do not have to be held there for an extra 6 months. Those do not hold up, supposedly, but at least I went through the process.

I myself did not get the disability appeal. I did not. I got to the point in life that it really did not matter, but I kind of took the stand whenever I got here to speed up the process because I know how long it can be and how hurtful it can be, and finally, most of them give up rather than get what is owed to them. And it is my job, I feel like to continue to fight for that.

So, if you see those come up, please let us know. We will continue to work hard for you, and thank you for being here.

Chairman TAKANO. The gentleman yields back.

I recognize Senator Blumenthal for 5 minutes.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thanks, Mr. Chairman. Thank you all for being here today, and thank you for your service to our Nation.

I am sure there may be veterans here or are listening from Connecticut, and I want to thank them as well.

Many of you have spoken about the priorities that I share and that I have worked on during my time in the United States Senate—veterans suicide is one of them, access to health care services for women veterans, and support for veteran caregivers of all generations, just to name a few.

The President's budget for the coming fiscal year increased the overall appropriation request for the Department of Veterans Affairs, but I am very concerned that this proposal still fails to provide adequate resource for maintaining and improving VA facilities.

The modernization of these facilities, particularly in the health care area, is critical to preventing a path to privatization. I believe privatization is anathema. Most of the Connecticut veterans, at

least the ones I have spoken to, agree that privatization is to be avoided.

So investments in major and minor conversation in addition to funding for nonrecurring maintenance is absolutely necessary.

I will give you one example. The VA in West Haven, the hospital there, has antiquated infrastructure in its operating rooms, so that they are functioning right now at about 30 percent of capacity. They were completely incapacitated for 3 months because of flooding. They are now operating at 30 percent of capacity because they lack the equipment necessary to sterilize the tools and equipment used in surgery.

Think of it for a moment. As many as two out of three veterans needing surgery are either delayed or sent elsewhere because the VA hospital in West Haven cannot clean the tools and equipment they need for surgery. They are going to lose their certification. They are going to lose docs who want to work there. The strength of veterans' health care is the docs and staff and administrative personnel, the talent, that it can attract. If they cannot sterilize tools and equipment, what can they do?

Well, what is the solution? A new facility. That is 5 years away, according to the VA most optimistic projection, 5 years away for a permanent new facility to sterilize tools and equipment at this major hospital.

So, in the meantime, they have said, "Let us get a trailer. Let us get a mobile facility, stop gap, temporary." How long will that take? A year. A year. Can you believe it?

I do not know how common this problem is around the country, but in my view, the President's Budget Request has to address it more effectively because right now we are taking too long to provide the first-rate, world-class medicine that our veterans deserve in West Haven.

I know my colleagues, many of them, have shared with me their frustrations with similar kinds of capital needs; that is, the need to rebuild and renovation, the capital equipment, the infrastructure.

So I invite your comments. I am sorry that I have taken longer than I thought I would to talk about this issue.

Yes, sir.

Mr. ZAMPIERI. Yes, sir. You have hit it perfect. In fact, West Haven, Connecticut, in addition to those surgical problems, the Blind Center in West Haven, which is one of the original ones from 1950s, they had flood damage due to broken pipes, and we have been waiting 3 years for them to fix it.

So the bed inpatient count for blind rehabilitation at that facility has been reduced to like 40 percent. That Blind Center serves all of New England, blind veterans from Maine, Massachusetts, Rhode Island. That is where they are supposed to go, and the waiting times—it is because of the construction problems, and I think most of the bipartisan comments would be that, yeah, the VA does not do a good job at construction. But it still drags on and on.

Senator BLUMENTHAL. I just want to finish, and I apologize for taking a little more time.

That comment is really so important and compelling, and I thank you for it.

I also want to make clear that what I have said here is in no way a criticism of the dedicated doctors, physicians, surgeons, nurses, administrative staff at the West Haven Hospital. They are working with one hand tied behind their backs, no fault of theirs.

The VA here in our Nation's Capital is hamstringing them because of the construction delays and impediments that it has created.

So I have written to the Secretary asking him personally to expedite this situation.

But as much as I hope that he will personally intervene, that is no solution nationwide, and your presence here today, I hope will provide a powerful impetus for us to unite on a bipartisan basis and demand better of the VA when it comes to these kinds of capital investments in our veterans care.

Thank you so much, Mr. Chairman.

Chairman TAKANO. Thank you, Senator Blumenthal.

I now recognize myself for 5 minutes.

With all due respect to my Ranking Member, it is true that VA investments have increased, but that does not necessarily gainsay that there is a privatization agenda afoot by some.

We have a former Secretary of the Veterans Affairs Department in this administration, the first one that has claimed that a privatization agenda was what in part forced him out.

I am alarmed by the percentage increase in spending on care in the community. It is a tremendous percentage increase, and while it is less than the absolute spending on medical care, if it continues to increase at that rate, it is going to put pressure on the internal capacity of the VA.

Even as we have spent this money, increased amount of money, we still have 45,000 positions that remain unfilled, mainly at the Veterans Health Administration, and this is very concerning.

The Secretary and everybody on both sides of the aisle pretty much has said, on both the House and Senate Committees, have enunciated an opposition to privatization of VA, and we are talking in particular about health services. But, in fact, careful manipulation of formulas, access standards, the way those access standards are implemented could definitely put us on a glide path very quickly toward an evisceration of the internal capacity of the VA, and what that would mean, frankly, community care is going to be more costly. And it is going to put pressure on future veteran use in terms of increased out-of-pocket cost to that veteran.

It is not going to be a better deal for the relationship, and it will not be a better deal for the veteran. And that is why I think so many veterans service organizations are concerned about what may be going on.

So, as Chairman of the Veterans' Affairs Committee on the House side, I am interested in keeping the proper proportion, the proper balance.

There has always been—always been a use of outside private contractors where the VA could not provide those medical services in-house, and there is not a medical network, a private medical network in this country, which does not coordinate the care in some way in a way that the VA coordinates the care and builds its own physician provider base.

So that being said, I want to ask a question of Ms. Ramos—Ms. Alvarado-Ramos. Bienvenido.

As you may know, the total population of women veterans is expected to increase over the next decade, and women make up the fastest-growing cohort of veterans.

Knowing this, our Committee has stood up a women's health task force led by my colleague, Congresswoman Brownley.

What are some of the most critical needs of women veterans, and what policy recommendations can we enact to address those needs?

Ms. ALVARADO-RAMOS. Probably the highest need is on the issue of emotional wellness or behavioral health because women—because of having been a minority—and I came in 1971 into military service when we were 2 percent of the military force. The issues, saw military sexual trauma, issues of being able to manage their families alone, you know, sometimes being dual service families. There is a lot of pressure on women veterans having served in which they emotional wellness issues surface, and behavioral health and emotional wellness if the root cause of a lot of the issues that we are dealing with in the States and the Federal VA—homelessness, unemployment, child abuse, in many cases subject abuse.

And, therefore, if we are able to upstream, be able to deal while they are still no active due in ensuring that they are well as they leave the military, then that is going to transpose into the community, but if they need the services, if we need the services, it is important that the network has the capacity and also the gender-sensitive care that is needed for women to be able to get the care that they need.

Chairman TAKANO. Thank you for your response.

My time is up, and I want to now recognize the gentleman from South Carolina, Mr. Cunningham, for 5 minutes.

REPRESENTATIVE JOE CUNNINGHAM

Mr. CUNNINGHAM. Good morning. I want to thank each and every one of you all for being here this morning and sharing your time with us. That is your most valuable resource, and it means a lot that you are here.

I represent the First Congressional District of South Carolina, which goes from Charleston all the way down to Hilton Head. Out of all South Carolina districts, it has the highest population of veterans in the entire State, and I can tell you how proud I am to be able to claim that piece.

Mr. Washington, this question was for you. As we all have family members or friends who have cared for others, we often realize it is the caregiver who suffers a lot as well. And sometimes attention is not placed enough on them.

As you know, the VA MISSION Act improves caregiver programs by providing relatives or friends who care for eligible veterans, a stipend, training, and access to health insurance and counseling.

While I believe we all agree our next steps should be to expand caregiver services to veterans of all—but beyond that, what else can we be doing to not only support the veterans but to support those who also support veterans, to support the caregivers and make sure they have everything that they need to care for our veterans?

Mr. WASHINGTON. Thank you, sir, for the question. I just want to let you know that I am also from Charleston, South Carolina, so thank you.

And that I think what we need to do is probably look at some kind of community-based sharing of mental health issues so that our veterans will have someone to turn to and also to make sure that the caregivers is implemented with a good oversight program to kind of keep watch on what is going on with the caregivers.

Again, I would like to thank the Congress. This has been an initiative that has been going back for a very long time of providing for caregivers because it takes a lot away from them to have to—a change of life for them as well, too, to help that particular veteran get all the needs and care that they possibly can.

So I would just think a little bit more transparency on community-based health that can help these veterans out when they can.

Mr. CUNNINGHAM. Thank you, Mr. Washington. I hope to see you back home here soon.

I reserve the rest of my time and yield back.

Chairman TAKANO. You wish to yield back?

Mr. CUNNINGHAM. I yield back.

Chairman TAKANO. Is Senator Sinema—she left. She comes and goes.

[Laughter.]

Chairman TAKANO. I was like I looked. She was here a moment ago.

That looks like it concludes all of our questions, and I will ask Dr. Roe if he has a concluding statement.

Dr. ROE. Just very briefly.

One of the things that passed under the radar screen last March were the inclusion of all the State veteran homes that were on the backlog. That is a huge deal. I think those are tremendous. Everywhere I visited a State veteran home, those have been really well received and well done, and the veterans are well served there. So I think that got passed over very quickly.

Last week, I guess it was, the Chairman held a roundtable, which was the second one we have had in the last few months, on veteran suicide and what we can do to help lower that rate.

I got very frustrated with that. When I look back at 2003 and we as a Nation were spending about \$2 billion a year, now we are spending \$8 billion a year, and the needle has not moved. I thought if we are continuing to do that, let us do something different.

So if you have ideas out there, please bring them to us, and we will be glad to listen to them because that is a tragedy. When you think if it is 20 people a day, that is a huge number of people in a year's time.

The other good news—and there is a lot of good news—I just saw where the veteran unemployment is 2.7 percent. That is remarkable to have an unemployment rate that low.

I will say this and with some levity, but Presidents' budgets make good doorstops. I have seen that over the years. The House and Senate appropriate the money, and we will decide how it is divided out and so forth. I think we can do that. We have been doing it for 200-plus years.

One of the things that has been brought up—and I think Senator Blumenthal did—which was extremely important, a third part of that VA MISSION Act was the AIR Act, and that is how our VA is going to look. And I applaud the Chairman for doing a 2030 view of what the VA will look like, and we even talked about what is the VA going to look like in 25 years.

I am amazed at how fast 25 years goes by, and we should be thinking about that now because the current VA cannot look like it does now 25 years from now because the demographics of the country are changing. People are moving from the Northeast to the South and West.

In 2045, there are going to be 12.5 million veterans because of an all-volunteer Army as opposed to ours which was a drafted Army. So we have got to look different, and we have got to provide the services closer to where the veterans live. Instead of having the veteran travel long distances in to see the VA, put the VA out where the veterans are.

I agree with you, Tom, that the vet centers are great. The ones I have been in are incredibly impressive places to be.

I will finish by—oh, the last thing—and I 100 percent agree with this. Our practice could hire a doctor before the VA could get the paperwork signed in, and the HR Director for the VA is going to come see me this week. We are going to start working on that. They have got to speed that up. I cannot tell you how many of my colleagues have said, “Look, Phil, I want to go to work at the VA, but I have got to pay my bills,” and so this is nurses, doctors, PAs, other people that make the VA function as it should be. I hear you loud and clear.

Again, thank you all for being here.

Mr. Chairman, thank you for allowing me to say a few closing words.

I just appreciate what each and all of you do every day for our Nation’s veterans.

I yield back.

Chairman TAKANO. Thank you, Dr. Roe, and I am very happy to hear you are going to see the HR Director. I hope you will pass on to me whatever you learn about what seems to be the impediments in the hiring process. I hear anecdotal stories all the time about people applying, doctors, specialists that are applying for jobs at the VA that are posted, and they do not hear back.

As you know, a specialist, they are highly sought after. There are shortages in private-sector medicine, and as I have said many times before, in my part of California, Inland California, we have a shortage of both family physicians and specialists as well as medical professionals of all different stripes.

In the context of that shortage, of course, it is going to be difficult for the VA to fill its vacancies in areas such as mine, and increased choice, an emphasis on choice, does not solve the problem because veterans are going to face long wait times and access issues, even if they are referred out into the community.

Even with the full employment we have, we have a skills gap, a credentialing gap, a professionalization gap, and we have an opportunity to upgrade our workforce, especially our medical workforce. And I think we need to—and this is something you and I

have discussed many times—is our mutual interest in a graduate medical school education, and I would take it further. We need to provide opportunities, affordable opportunities for more Americans to work in these health professions, to serve our veterans, but to serve our Nation, frankly. We have communities all over this country that are facing these challenges.

With that, I will conclude my remarks.

Thank you all for the work you do on behalf of our veterans, and what I love about my work is that the solutions we find are for homeless veterans, for women veterans, for Native American veterans, for homeless veterans. There are templates for solving those issues with the public at large.

So thank you for the work you do, and with that, these proceedings are adjourned.

[Whereupon, at 11:35 A.M., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

**NATIONAL ASSOCIATION OF STATE DIRECTORS
OF VETERANS AFFAIRS**



Joint Hearing of the House and Senate

Veterans' Affairs Committees

March 12, 2019

Presented by

Lourdes E. Alvarado-Ramos

President, National Association State Directors of Veterans Affairs

Director, Washington State Department of Veterans Affairs

INTRODUCTION

Chairman Isakson, Chairman Takano and distinguished members of the committees on Veterans Affairs, my name is Lourdes E. Alvarado-Ramos, President of the National Association of State Directors of Veterans Affairs (NASDVA) and Director of the Washington State Department of Veterans Affairs.

NASDVA is comprised of the State Directors of Veterans Affairs for all fifty States, the District of Columbia, and five territories: American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands. Here with me today are General Les Beavers, NASDVA Executive Director, and former Commissioner of the Kentucky Department of Veterans Affairs and John Hilgert, Director of the Nebraska Department of Veterans' Affairs and NASDVA Senior Vice President. We are honored to present the collaborative views of our association.

States are multidimensional service providers to Veterans. The State Departments of Veterans Affairs (SDVAs) serve at the intersection of local communities and the federal government as a nexus for community partners other State Agencies and any other interested party. SDVAs as a whole, are second only to the U.S. Department of Veterans Affairs (VA) and our role within this system continues to grow. Our mission includes advocating for all our nation's Veterans, their family members and survivors to access their earned federal and state benefits. The State Departments of Veteran Affairs (SDVAs) provide services in the following areas: advocating for Veterans' access to VA Healthcare (including mental health); filing disability claims and appeals on behalf of Veterans; administering and operating State Veterans Homes and Veteran Cemeteries; connecting women, minority, LGBTQ and rural Veterans to needed services; and acting as the State Approving Agency for GI Bill use.

The SDVAs support the establishment and operation of Veteran Treatment Courts; support community efforts to end and prevent Veteran Homelessness; award grants to local governments and non-profit organizations that provide assistance to Veterans; and assist service members with transition and employment services. Furthermore, SDVAs often serve in helping Veterans in ways that may not fit into any established program. To this point, SDVAs are well positioned and often have the capacity to assist the VA in the development and deployment of new programs and initiatives. The combined services that SDVAs provide tend to have a much broader connection to our nation's Veterans than those who are currently enrolled and utilizing

VA services. Despite constrained State budgets, States collectively contribute over \$10 billion each year in service to our nation's Veterans and their families. NASDVA, through its Member States and Territories, is the single organization outside of the VA that serves and represents all of America's nearly 20 million Veterans.¹

Delivery of meaningful services and support is often best coordinated at the local level. To this end, as governmental agencies, SDVAs are tasked and held accountable by our respective Governors, State Boards or Commissions. SDVAs are responsible for addressing the needs of our Veterans irrespective of age, gender, era of service, military branch or circumstance of service. On a daily basis, State Directors and their staffs are confronted with unique situations in caring for all Veterans and their families. However, SDVAs cannot do this important work alone.

USDVA – NASDVA PARTNERSHIP

The formal partnership between USDVA and NASDVA continues to yield positive results for our Veterans nationwide. Since NASDVA's incorporation in 1946, there has been a long-standing government-to-government cooperative relationship. This relationship was formalized through a Memorandum of Agreement (MOA) between USDVA and NASDVA originally signed in 2012 and updated on February 25, 2019 between VA Secretary Robert Wilkie and NASDVA President Lourdes E. Alvarado-Ramos.

The MOA established the "Abraham Lincoln Pillars of Excellence" award to recognize best practices from NASDVA members that developed effective programs to address five issues: improve Veteran's experience, improve access to healthcare and services, improve claims and appeals processing, suicide prevention and innovative State programs. For 2019, the sixth year of program awards, the VA Secretary presented seven awards to the following states: California, Nevada (X2), District of Columbia, Illinois, Maine, and Michigan. For 2020, NASDVA intends to focus on and recognize excellence in effective programs to address: Eliminating Veteran Suicide, Homeless Prevention, Eliminating the Claims and Appeals Backlog, Consumer Experience with VA Benefits and Services and Innovative State Programs.

¹ Veteran population estimate, as of September 30, 2017 (VetPop 2016) 19,902,577. See FY17 GDX available: <https://www.va.gov/vetdata/Expenditures.asp>

VA FUNDING

Congress' work to improve overall funding for healthcare, claims/appeals processing, cemetery operations, and homeless Veterans' programs is vital to meet the needs of a new generation of Veterans who require extensive medical and behavioral care and transition to our communities. While there is significant focus on our returning service members, we must continue the critical work of serving all Veterans, especially the large cohort of aging Veterans. Full Congressional support of the President's FY2020 VA budget request is vital to meet the growing needs of Veterans to fulfill the VA's mission. Please know that NASDVA is committed to working with Congressional and VA leaders to ensure scarce resources are allocated to priorities that will meet our Veterans' most pressing needs. As the VA continues its transformation journey, NASDVA supports a continuation of new initiatives, relentless vigilance in ensuring effective and efficient program execution, and a continued focus to deploy resources where Veterans can best be served.

U.S. CENSUS AND VETERAN STATISTICS

Understanding the customer is critical to effective and efficient service delivery. To that end, the 2020 U.S. Census must include in its questionnaire military service information. This critical data set, which was abandoned in the 2010 census, wherein, status is no longer connected in the decennial questionnaire, is an issue of extreme urgency and importance and warrants Congressional attention as census questions are in development. Census data drives the predictive models that assist both VA and SDVAs to better serve our veterans. States leverage these models and data to make informed budget decisions. For States with constitutionally mandated balanced budgets, timely, accurate, and predictive information is vital for providing efficient and effective service. NASDVA urges Congress and VA to intervene with the US Census to obtain military service information.

VETERANS HEALTHCARE BENEFITS AND SERVICES

NASDVA supports the implementation of the provisions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (The MISSION Act). Given the

demographic and geographic diversity of U.S. States and Territories, NASDVA recommends authorization and funding based on a veteran-centric approach. The Veterans Health Administration (VHA) is a comprehensive healthcare system that provides, through a variety of means, the full spectrum of care for our Nation's Veterans; in many cases, care that is provided nowhere else. VA also conducts extensive research and training that benefits our country writ large. Future plans for Veterans' healthcare must allow VA management flexibility, perhaps at the regional Health Care System level, that emphasizes an integrated (VA and Non-VA) and flexible care model. A proper mix of simplified care delivery should be based on Veterans' needs, location, accessibility, and availability of services. Decisions for care within VA or in the community should be determined by the Veteran and his/her provider.

State Directors, represented by NASDVA, fully support efforts to increase Veterans' access to VA Healthcare. This includes the continued involvement of SDVAs with VA Medical Centers (VAMCs) to collaborate in enrolling Veterans and eligible family members in the VA healthcare system. This collaboration also continues to address expansion of Vet Centers, the deployment of mobile health clinics, and maximizing the use of tele-health services. We commend VA's efforts to address behavioral health, rural Veterans, Military Sexual Trauma and women Veterans' health issues.

NASDVA's priorities for the care of our Veterans are generally consistent with those of the VA, especially in the area of behavioral health and suicide prevention. While the VA has made commendable progress on suicide prevention, there is still much work to be done given that the rate of suicide is 1.5 times higher for veterans than it is for non-veterans.² It is critical that SDVAs work with the VA healthcare system to address this high priority clinical issue. NASDVA proposes the creation of "outreach grants" from the USDVA to SDVAs. These grants could potentially address shortfalls and needed improvements in suicide prevention and awareness outreach.³ Arguably, states are in a better position and closer to vulnerable veterans that need help. The VA and other government health care networks must serve as the core for providing health care services. External networks and preferred providers should be expanded to provide care where VA services are not available. In short, NASDVA supports an "all of the

² GAO-19-66. VA Suicide Prevention Media Outreach. Available: <https://www.gao.gov/assets/700/695485.pdf>

³ GAO-19-66. VA Suicide Prevention Media Outreach. Available: <https://www.gao.gov/assets/700/695485.pdf>

above” strategy for health care delivery which recognizes the diversity, geography, and demographic makeup of today’s Veterans.

It is imperative that VA, specifically VHA, receives the funding required to care for Veterans who are enrolled today. While the number of Veterans is decreasing, the complexity of their care is increasing. VHA must have the resources necessary to recruit and retain doctors, nurses, and other professional staff. A policy of wholesale privatization or contracting outside a Veteran-centric environment, may diminish VA experience. Recognizing that under some circumstances it is necessary and appropriate for Veterans to receive care at facilities and providers outside VA, reimbursements for service/care must be prompt and meet industry standards. Slow payments discourage providers to participate in providing care to our Veterans.

Telehealth services are now mission critical to the future service delivery of VA healthcare and NASDVA applauds the VA as a world leader in this practice. Telehealth is particularly critical to rural Veterans when just in time access to mental health services is not available or when they have to travel long distances to see a provider. Any barriers, statutory or regulatory, that exist and impede delivery of telehealth services to Veterans must be removed particularly across State lines. SDVAs can play an important role in connecting rural Veterans to telehealth. Through federal funding, SDVAs can provide outreach and connect our most vulnerable Veterans to life saving programs. This outreach effort will help close the gap in access to mental health care in rural, American Indian/Alaska Native and other underserved minority communities.

To meet the demands of the 21st century Veteran, we are also prepared to assist VA as they develop and deploy the Electronic Health Record (EHR). This complex, multibillion dollar modernization program is essential for the care of Veterans in the future. This time, failure is not an option and the States are positioned to advocate, promote and provide VA with timely feedback for the success of this mission.

STATE VETERANS HOMES

The State Veterans Home (SVH) Program is the largest and one of the most important partnerships between SDVAs and VA. SVHs provide over 51% of total VA long-term care and is a cost-efficient partnership between federal and State governments. SVHs are the largest

provider of long-term care to America's Veterans, providing a vital service to elderly and severely disabled Veterans with skilled nursing, domiciliary, and adult-day health care services. There are 156 operational SVHs in 50 States and the Commonwealth of Puerto Rico.

NASDVA and the National Association of State Veteran Homes (NASVH) have actively advocated for the principle that Veterans in our homes are entitled to the same level of support from VA as Veterans placed in Community Living Centers and VA community contract nursing homes. Both national associations have been engaged with Congress to demonstrate program needs and needed levels of funding support. We maintain that the benefit is to the Veteran, regardless of where he or she chooses to receive their care. To ensure State homes can continue to operate and provide high quality care, the Provider Agreement provision to care for the most vulnerable and compromised Veterans (70% or above service connected) must be maintained and strengthened in future legislation. Furthermore, care must be taken to ensure Veterans are able to utilize VA for services and specialty care not traditionally part of nursing home operations. For example, a Hepatitis C diagnosis treated by a specialist outside the SVH (with specialty medications) is complex and should be VA's responsibility.

NASDVA also has concerns about behavioral health and the future incidence of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and other conditions in the aging Veteran population. While there are war-related traumas that lead to PTSD in younger OEF/OIF Veterans, aging Veterans are exposed to various catastrophic events and traumas of late-life that can lead to the onset of PTSD or may trigger reactivation of pre-existing PTSD. Reactivation of PTSD has been seen more frequently in recent years among World War II, Korean and Vietnam War Veterans and has been difficult to manage. VA has limited care for Veterans with a propensity for combative or violent behavior and the community expects VA or State Veterans Homes to serve this population. NASDVA and NASVH recommend a new Grant Per Diem scale that would reflect the staffing intensity required for psychiatric beds and medication management. SVHs and VA Community Living Centers are unable to serve care intensive psychiatric patients; therefore, VA can't turn over hospital psychiatric beds because of a lack of community psychiatric step-down capacity. This level of care is critically needed in our States.

NASDVA and NASVH support a continued commitment to the significant funding of the State Veterans Home Construction Grant Program as demonstrated last year. It is important to the veterans we serve to keep the existing backlog of projects in the State Extended Care Facilities Construction Grant Program at a manageable level to assure life safety upgrades and new construction. In its FY 2020 budget proposal, VA is requesting \$150M for the State Veterans Nursing Home Construction Grant Program. NASDVA strongly supports increasing funding to at least \$200 million.

Both VA and our State Veterans Homes (SVH) are experiencing healthcare provider shortages. These shortages are projected to continue for the next 15 years as the baby boomer generation ages. It is imperative that VA continues its recruitment and retention efforts in order to have the quality and quantity of providers to care for eligible Veterans.

Regarding implementation of the Electronic Health Record, our State Veterans Homes with 30,000 beds across the nation, should have access to the system. In the past, select facilities have had read only access. Full access, as planned for community clinics and providers will allow facility health care providers to seamlessly coordinate the care of our Veterans.

Finally, NASDVA recommends that VA, in consultation with NASVH, begins an evaluation process to implement an Assisted Living level of care or enhanced domiciliary grant program. Currently there are only two levels of care: Domiciliary or independent living for Veterans unable to thrive in the community and Skilled Nursing care. The Domiciliary rate does not cover the cost of caring for this higher level of care. NASDVA (and NASVH) will be asking VA to collaborate on this critical effort and ensure that Veterans have options, especially when unable to age at home.

VETERANS BENEFITS SERVICES

State Directors continue to take on a greater role in the effort to manage and administer claims processing. Regardless of whether the State uses State employees, nationally chartered Veterans Service Organizations (VSO) and/or County Veterans Service Officers (CVSO), collectively, we have the capacity and capability to assist the Veterans Benefit Administration (VBA).

NASDVA applauds VA's efforts to overhaul its disability claims process administered by the Veteran Benefit Administration (VBA) and although we are optimistic, NASDVA remains concerned that there is a backlog and emphasizes that resources and focus must be kept on adjudicating claims in a timely manner. In December 2013, VA testified before the Senate Committee on Veterans Affairs that it had made significant progress in executing their benefits transformation plan, and had significantly reduced the backlog from a peak of 611,000 in March 2013. While the backlog is currently much smaller at 85,500, this number should be closer to zero. VA should continue to focus resources on continuing to reduce the backlog while working with SDVAs. Recognizing that there is a wide range in the resources available in individual States, NASDVA recommends serious consideration to making federal funding available to States to assist with efforts "on the ground" to further reduce the backlog and maintain progress on expediting existing and new claims.

Additionally, the VBA should review its metrics and incentives. In theory, State Service Officers have 48 hours to review claims for accuracy and potentially prevent a need for an appeal. In practice, the VBA is "pushing" claims through in less than 48 hours in order to improve "the flow." While it is admirable for the VBA to be timely, an accurate claim that alleviates a need for an appeal is arguably better than a claim rushed in error. VBA can and should ensure that its management of claims processing is veteran-centric. NASDVA advocates reforming the VA administrative appeals process to streamline VBA appeal procedures and decisions and allow for seamless transition to and enable decisions in the Board of Veterans Appeals (BVA). By placing significant focus on the process within VBA (Regional Offices) prior to appeals being sent to BVA, due diligence and due process (in favor of the Veteran) can be maintained while creating an environment where appeals requiring VBA or BVA adjudication can be decided on the merits of the original claim; in a timely manner. In addition, while transforming to a streamlined appeals process which is more efficient and less costly for taxpayers, VA will need (and NASDVA supports) a short-term funding increase to be able to resolve the inventory of appeals that are pending in the current system. As the "front line" providers of Veterans' claims service and representation, NASDVA is ideally positioned to work with VBA and BVA to assist in reforming and transforming the appeals process.

A success story of government-to-government collaboration between VA and NASDVA is the work that led to the modernization of the Claims Appeals Process. A multistate team joined VA, Veterans Service Organizations (VSOs) and Congressional staffs to develop a product that will change a system that was failing our Veterans. NASDVA commends Congress for passing legislation leading to appeals modernization, which reduces backlog and creates a more informed Veterans experience.

State Approving Agencies (SAA) function in nearly all States to monitor and approve educational institutions for receipt of Veterans' education benefits. SAAs assess and approve educational institutions and training programs for GI Bill education benefits. Twenty-six SAAs are in State Departments of Veteran Affairs. As a part of this effort, NASDVA works closely with the National Association of State Approving Agencies (NASAA). In 2006, the SAAs secured a mandatory funding model to ensure their programs would have sufficient funding each year. With the important passage of the Post-9/11 GI Bill, the SAAs' mission expanded with more compliance requirements but no additional resources. Without adequate resources, SAAs report that it is harder to sufficiently monitor and assess all academic programs under their charge. Under the current (and proposed) VA model, the requirements placed on SAAs have increased while, in most cases, funding has decreased. Additionally, the funding source for the program is increasingly unstable. NASDVA requests a revision of the SAA Total Requirement and Allocation Model.

BURIAL AND MEMORIAL BENEFITS

NASDVA appreciates the National Cemetery Administration's (NCA) collaborative partnership with States, Territories and Tribal governments. The Veterans Cemetery Grants Program (VCGP) complements NCA's 136 national cemeteries and is an integral part of NCA's ability to provide burial services for Veterans and their eligible family members. State, Territory and Tribal cemeteries expand burial access and support the NCA number one goal of "increasing access to a burial option in a National or State Veterans cemetery" and by FY2021 provide burial services to 95% of all Veterans within in a 75-mile radius of their home. There are currently 112 VCGP cemeteries located in 48 States, two (2) territories (Guam, Saipan), the Commonwealth of Puerto Rico and eleven (11) operational tribal cemeteries. In fact, these cemeteries provided

over 39,000 interments in FY 2019, which is 22% of the total interments by both NCA and VCGP cemeteries.

We recommend the FY 2020 construction grant program budget be increased to at least \$60M comprised of \$50M for construction and \$10M specifically designated for improvements and emergent needs in State and Tribal cemeteries. This modest increase to the \$45M budget proposal would allow funding of some new State cemeteries and upgrade projects that currently go unfunded while also allowing NCA to respond to emergent requirements.

NASDVA fully supports the NCA goal of ensuring that State and Tribal Veterans cemeteries are maintained through a Compliance Review Program to the same standard of excellence applied to the national cemeteries. This aligns a review process for VA grant-funded State and Tribal Veterans' cemeteries to achieve National Shrine Standards. As NCA pilots the feasibility of weekend interments, the budget impact cannot be an unfunded mandate for neither VA nor the States. The operational cost for State Veterans Cemeteries depends on the plot allowance for Veterans. There is no plot allowance for the interment of family members. NASDVA recommends that Congress appropriates funds to increase the plot allowance. This would assist the States to maintain parity with National Cemeteries.

WOMEN VETERANS

Women Veterans are the fastest growing Veteran population. Women now comprise 20% of the Armed Forces and assume roles in nearly all military occupational specialties. The elimination of the combat exclusion rule by the Department of Defense in 2016 means that women will fill 100% of occupational specialties soon. There are several areas NASDVA believes VA can work on to close gaps in service, ensure continuity of care, and address the needs of women Veterans.

Veterans are impacted by the provider shortage for the delivery of gender and transgender specific healthcare. In addition, we understand the VA priorities include addressing needs of victims of Military Sexual Trauma (MST) to include those who served in the National Guard and Reserve. Due to an increasing volume of Veterans with MST, compatible care and provider alternatives need to be deliberately extended to all those Veterans who might otherwise be dissuaded from seeking treatment at the VA. As well, work must continue on the

reconciliation of MST claims for PTSD recommended in the Office of Inspector General Report #17-05248-241, dated 21 August, 2018.

Additional gender specific healthcare includes infertility care. NASDVA advocates progressive support for veterans with infertility issues caused by illness or injury while serving in a military capacity. VHA must also ensure that Women Veterans have access to and receive in a timely manner, high quality, gender specific and individualized prosthetic care that will allow them to improve their quality of life.

With the relatively recent VA investment of state-of-the art women's clinics across the country, there still exists a disproportionate and non-standard availability to access gender-specific healthcare relative to the population of women Veterans. The decision-making and planning for new clinics or renovation of existing clinics must be data driven to ensure Veterans receive care commensurate with the population. As noted early, the need for census data is critical for this type of effort.

The largest emerging population of homeless Veterans is women. Recent efforts across the country to end and prevent Veteran homelessness are commendable and deserve recognition. We know the true numbers of this emerging population are underrepresented due to prescribed models of addressing homelessness. For example, a victim of domestic violence fleeing an abuser and living with a friend is not considered homeless. NASDVA recommends, and will work with VA and HUD to allow flexibility in their definition of homelessness and revitalize transitional housing models to better serve women Veterans especially those with children. NASDVA also advocates for passage of HR 95, the Homeless Veterans Families Act. Currently, the VA does not have the authority to provide the reimbursement for the costs of services for minor children of homeless Veterans. This issue disproportionately impacts women Veterans as women bear the primary responsibility of child raising. A GAO report found that this inequity led to financial disincentive for housing providers and in turn, limits housing for veterans with young children. HR 95 would eliminate this issue by allowing VA to reimburse providers for 50 percent of the costs of housing minor dependents of homeless Veterans when the Veterans receives services from the grant recipient.

Homeless Veterans consistently identify childcare as a top unmet need. The cost is a common barrier for many as they try to seek employment and healthcare. NASDVA supports

HR 955 and S 319 to break down the barriers to access for eligible veterans who require childcare support while seeking employment or healthcare services.

Women Veterans are more likely to commit suicide than non-veterans.⁴ NASDVA recommends that VA develop a mechanism between VHA and VBA to identify at risk veterans at the time a claim is initiated or when a service is requested through the VBA. In short, any seams between VBA and VHA need to be mitigated to identify veterans at risk of committing suicide. NASDVA recommends that more efforts through the VA Experience Office be made to support the community efforts to prevent suicide. Data indicates that 70% of the Veterans who take their own lives do not engage with the VA. The community must be supported to take on this monumental task of suicide prevention.

MINORITY VETERANS

Veterans in Island Territories have had significant issues with services due to their isolation. For example, during recent hurricane catastrophes in Puerto Rico and the Virgin Islands, the VA was one of the only available providers yet category 7 and category 8 veterans were not accepted and thus did not have any viable options for their urgent medical needs. NASDVA recommends provisions in VA healthcare to allow care to all veterans in VA facilities during catastrophic events.

Native American Veterans are underserved on their reservations. Veteran Service Organizations (VSO) and SDVA do not have the capacity to provide services consistently and until recently, could not accredit Tribal Veterans Representatives (TVR). We commend VA for the recent rule changes that allow SDVVs to accredit TVRs and/or allow for Tribes to seek their own accreditation. This will ensure TVRs serve their nations within their cultural beliefs and sovereignty and promote self-sufficiency.

⁴ After adjusting for age, in 2016, the suicide rate for women Veterans was 1.8 times greater than the suicide rate for non-Veteran women. VA National Suicide Data Report 2005-2016. Office of Mental Health and Suicide Prevention. (2018). Available: https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf

HOMELESSNESS AMONG VETERANS

NASDVA commends VA's effort and continued emphasis on ending homelessness among Veterans. States will continue to develop and support outreach programs that assist VA in this high priority effort, particularly in further identifying those Veterans that are homeless and programs to prevent homelessness. As partners with VA at the nexus of local communities, we are focusing on addressing the multiple causes of Veterans' homelessness e.g. medical issues (mental and physical), legal issues, limited job skills, and work history. We appreciate the continued funding for specialized homeless programs such as Homeless Providers Grant and Per Diem, Health Care for Homeless Veterans, Domiciliary Care for Homeless Veterans, and Compensated Work Therapy. It is vital to continue VA's partnership with community organizations to provide transitional housing and the VA/HUD partnership with public housing authorities to provide permanent housing for Veterans and their families.

We know that many stages of homelessness exist and likewise we know that many factors contribute to our nation's homelessness among Veterans. Contributing factors are alcohol and drug abuse, mental health issues, PTSD, lack of employment, and involvement with the justice system. To eliminate chronic homelessness, we must address the many root causes by providing the necessary mental health and drug treatment programs in conjunction with job skills training and employment. These collective programs must be adequately staffed and fully funded in the current and future budget. Another revolving door that appears to increase the rolls of homelessness among Veterans is the overburdened courts and corrections system.

NASDVA commends VA and HUD for their collaboration in increasing the number of VASH Vouchers. Unfortunately, in large cities with high costs of living, the voucher value is insufficient to allow the veteran to secure adequate housing. Some cities need cost of living adjustments to ensure the VASH voucher will actually cover most of the cost of affordable housing. NASDVA recommends that vouchers are tied to local markets to ensure they can support a veteran with secure permanent housing.

The VA Veterans Justice Outreach (VJO) Program is a prevention-focused component of VA's Homeless Programs Office (HPO), whose mission is to end homelessness among Veterans. Since the program was founded in 2009, VJO Specialists at every VA medical center have provided outreach and linkage to VA and/or community services for justice-involved Veterans in

various settings, including jails and courts. VJO Specialists are essential team members in Veterans Treatment Courts (VTC) and other Veteran-focused courts, as they connect Veteran defendants with needed VA services and provide valuable information on their progress in treatment. NASDVA supports increased USDVA funding for more Veteran Justice Outreach Coordinators to increase this valuable service.

VETERANS TREATMENT COURTS

States continue to recognize the increase in justice-involved Veterans, especially in the time shortly after discharge, and continue to work with leaders at the State level to create environments (through legislation and other means) that encourage the creation and support of Veterans Treatment Courts (VTC). After discharge, many Veterans suffer from severe mental and emotional problems that result in behaviors that are disruptive and often criminal in nature.

It is important that we all remain committed to seeking innovative ways to help justice involved Veterans become the productive Veterans that they were meant to be. Support for Bureau of Justice Assistance (BJA) and National Drug Court Institute (NDCI) orientation and training programs for jurisdictions interested in establishing VTCs is important to that effort. The States respectfully request support for increased funding to the BJA, so more jurisdictions can participate. Additionally, increased funding for multi-year grants to aid jurisdictions in the establishment and sustainment of VTCs is needed. Problem solving courts such as Veterans Treatment Courts can make life altering and society improving transitions as a form of direct help for Veterans.

TRANSITION ASSISTANCE PROGRAM (TAP)

In 2011, Congress passed the "Veterans Opportunity to Work and Hire Heroes Act of 2011" (VOW Act). The VOW Act requires that separating service-members attend the Transition Assistance Program (TAP) at their military installation within 180 days of separation or retirement. Currently TAP is a five-day workshop, three of which focus on employment services designed by the Department of Labor's Veterans' Employment and Training Service (DOL-VETS) and facilitated through a partnership with the Departments of Defense, and Veterans Affairs. However, there is no mandate to include each State's Veteran Employment and Workforce Services provided by the Jobs for Veterans State Grant (JVSG) into the curriculum. Additionally, there is no provision to include Veteran services and benefits from

each State's Department of Veteran Affairs. Recommend that DOL-VETS, DOD, and the VA incorporate each State's specific Workforce and Veteran Services overviews into the TAP curriculum in order to facilitate a smooth transition for the service member into the State of their residence. This would include a mechanism to connect transitioning service members to the Veteran services in the State he/she will locate in upon separation from their military service.

While we recognize the efforts and progress DoD has made regarding transition, SDVAs need service member contact information prior to separation in order to provide upstream services and to receive our new Veterans. NASDVA recommends the sharing of information such as civilian email and mobile phone numbers, which are more reliable than home of record addresses or military email accounts.

JOBS FOR VETERANS STATE GRANT (JVSG) MANAGEMENT BY DOL-VETS

SDVAs have clearly witnessed how viable employment is essential to a successful transition from uniformed military service to civilian life. To assist in this transition, the U.S. Department of Labor-Veterans Employment and Training Services (DOL-VETS) manages the Jobs for Veterans State Grant Program. However, the flexibility of the States to serve the employment needs of Veterans is greatly restricted in many cases by DOL-VETS. States should determine the agency that can best administer, control and fund this critical program. If placed in the State agency that administers Veteran services, it could help facilitate the priority placement of veterans in the job market and align our Veterans with education and vocational rehabilitation services provided by the VA. Ultimately, individual States' Chief Executives (Governors) should have authority to determine what organizational structure may best serve the employment needs of that State's Veterans and the workforce needs of the State.

We commend the continued emphasis on hiring Veterans for federal employment. The U.S. Department of Labor and the U.S. Department of Defense need to continue to promote awareness of the provisions and benefits under the Uniformed Services Employment and Re-Employment Rights Act (USERRA).

SUPPORTING VETERAN FAMILIES

Veteran families are an important part of the Veteran experience and recovery. NASDVA recognizes the role of families in the Veteran life cycle. The VA, States and

Congress, must recognize that the family unit serves and all programs and legislation must consider these unsung heroes. While the VA's Congressional authorization is to serve Veterans, more must be done to include their families and ensure their emotional and physical wellness. VA spends billions of dollars to provide care to the Veteran. If the family is not well, the probability for the Veteran to reach his/her highest level of functioning will be compromised resulting in the waste of precious resources.

CONCLUSION

Chairman Isakson, Chairman Takano and distinguished members of the committees, we respect the important work that you have done and continue to do to improve Veteran services and benefits. I emphasize again, that we are government to government partners with VA in the delivery of services and care to those who have served in uniform. SDVAs serve as a nexus and link to local communities. Our presence today illustrates your recognition of NASDVA's contribution and value in serving our nation's Veterans and their families. With your help and continued support, we can ensure our Veterans and their needs are adequately resourced and remain a priority. The difficult challenges we address today are critical investments, which become the foundation of our promise to serve those who have borne the battle and for their families, and survivors.

Thank you for including NASDVA in this very important hearing.

National Association State Directors of Veterans Affairs (NASDVA) Testimony Summary

- NASDVA continues to advocate for increased resources for State Departments of Veterans Affairs, as well as continued cooperation between VA and the State VAs.
- NASDVA is advocating for “full Congressional support” of the proposed FY2020 VA budget in order to ensure that VA is fully able to meet the needs of veterans. This includes having the funds necessary to ensure that community providers are reimbursed in a timely manner.
- NASDVA supports the implementation of the VA MISSION Act, and believes that the decision to seek care within VA or in the community should be made by the veteran and their care provider.
- Regarding mental health, NASDVA proposes the creation of “outreach grants” from VA to State VAs to help address shortfalls in suicide prevention and awareness outreach.
- NASDVA believes that veterans residing in State Veterans Homes are entitled to the same level of support from VA as Community Living Centers and VA community contract nursing homes. This includes the creation of a new Grand Per Diem program to help state homes cope with the staffing intensity required of veterans with a history of combative or violent behavior.
- NASDVA commends the passage of appeals modernization legislation, and recommends that federal funding be made available to State VAs to assist in “on the ground” efforts to reduce the appeals backlog.
- NASDVA requests that Congress appropriates funding to State Veterans Cemeteries in order to allow them to maintain parity with the National Cemeteries Administration. Additionally, NASDVA supports an increase in the plot allowance and expanding eligibility for burial in national cemeteries to all veterans.
- NASDVA wishes to point out that more work must be done for women veterans. Accommodations for MST care, infertility care, mental health, access to gender-specific care, and outreach to homeless women veterans are all areas in which VA and State VAs can and need to work together to improve the quality of care for women veterans.
- NASDVA recommends that HUD-VASH vouchers be tied to local markets to ensure they can support a veteran in acquiring secure permanent housing.
- NASDVA is advocating for increased support for Veterans Treatment Courts (VTCs) and the training programs that support the VTCs.
- NASDVA recommends that DOL-VETS, DOD, and VA incorporate State-specific Workforce and Veteran Services into the TAP curriculum. NASDVA also recommends that States take over the management of Jobs for Veterans State Grants (JVSIG) from DOL-VETS.
- NASDVA advocates that Congress and VA do more to support the families of veterans, citing the importance of family members in providing care to veterans.



Statement of the
Fleet Reserve Association
on its
2019 Legislative Goals

Presented to the:

U.S. House of Representatives and
United States Senate
Veterans' Affairs Committees

By

Robert Washington Sr.
National President
Fleet Reserve Association

March 12, 2019

The FRA

The Fleet Reserve Association (FRA) is the oldest and largest organization serving enlisted men and women in the active, Reserve, and retired communities plus veterans of the Navy, Marine Corps, and Coast Guard. The Association is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) and entrusted to serve all veterans who seek its help.

FRA was started in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

The Association testifies regularly before the House and Senate Veterans' Affairs Committees, and the Association is actively involved in the Veterans Affairs Voluntary Services (VAVS) program. A member of the National Headquarters' staff serves as FRA's National Veterans Service Officer (NVS) and as a representative on the VAVS National Advisory Committee (NAC). FRA's VSOs oversee the Association's Veterans Service Officer program and represents veterans throughout the claims process and before the Board of Veterans' Appeals.

In 2016, FRA membership overwhelmingly approved the establishment of the Fleet Reserve Association Veterans Service Foundation (VSF). The main strategy for the VSF is to improve and grow the FRA Veterans Service Officers (VSO) program. The newly formed foundation has a 501(c)(3) tax exempt status and nearly 800 accredited service officers with FRA.

The VSF is sponsoring the Healthy, Wealthy and Wise conference in Norfolk Va. in September 2019. The conference will provide subject matter experts in Aging, Health and Financial advice. There will also be a VSO training track. The audience will be those employees at the federal and state or local level who administer and navigate the VA, DoD and other agencies, providing veterans and active duty help.

FRA became a member of the Veterans Day National Committee in August 2007, joining 24 other nationally recognized Veterans Service Organizations (VSO) on this important committee that coordinates National Veterans' Day ceremonies at Arlington National Cemetery. The Association is a leading organization in The Military Coalition (TMC), a group of 33 nationally recognized military and veteran's organizations collectively representing the concerns of over five million members. FRA senior staff members also serve in a number of TMC leadership positions.

The Association's motto is "Loyalty, Protection, and Service."

Certification of Non-Receipt of Federal Funds

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

FY 2020 VA Budget

Submission of the Administration's FY 2020 budget request has been delayed. FRA supports initiatives to help ensure adequate funding for the Department of Veterans Affairs (VA), with special attention for VA health care to ensure access and care for all beneficiaries.

"Of the \$180 billion VA spent in 2017, the department paid disability compensation of \$73 billion to 4.5 million veterans with service-connected disabilities. VA spent a little less, \$69 billion, on medical care for more than 6 million veteran patients and medical research. Substantially less, \$14 billion was spent on the next largest set of programs, which provide education and vocational rehabilitation benefits for about 1 million veterans and their dependents, and the remainder paid for other programs and administrative costs."¹

The VA is widely recognized for its effective medical and prosthetic research program and FRA continues to strongly support adequate funding for medical research and for the needs of the disabled veteran.

Agent Orange/Blue Water Navy Reform

As we submit this testimony it is still unclear how the recent court litigation will impact Blue Water Vietnam veterans. The *Gray v McDonald* case pending before the U.S. Supreme Court pertains to VA's exclusion of Da Nang Harbor from the definition of "inland waterways." The US Court of Appeals for the Federal Circuit in Washington DC has ruled in favor of Agent Orange/Blue Water Navy veterans in *Procopio v Wilkie*. The petitioner argued on behalf of Blue Water Veterans saying that Navy veteran, Mr. Procopio, who never stepped foot on land in Vietnam, was exposed to Agent Orange during his military service off the coast of the Republic of Vietnam. Due to this exposure, he developed medical conditions consistent with other veterans who served on land, and were exposed to Agent Orange and should be entitled to a presumptive category, and thereby eligible for benefits.

The Association is not waiting on the courts and is grateful to the House Veterans Affairs Committee efforts last year to pass Agent Orange reform. The bill (H.R. 299) passed the House unanimously (382-0). Reps Dr. Phil Roe (TN) now Ranking Member, and the new Chairman Mark Takano (CA) should be applauded for their rapid introduction of reform legislation this year. FRA supports the "Blue Water Navy Vietnam Veterans Act" introduced in the House

¹ CBO "Possible Higher Spending Paths for Veterans' Benefits" December 2018.

(H.R. 299 & HR 208) that would clarify that service members serving off the coast of the Republic of Vietnam during the Vietnam conflict have a presumption for filing disability claims with the VA for ailments associated with exposure to the Agent Orange herbicide. FRA believes Congress should recognize that the so-called “Blue water” veterans were exposed to Agent Orange herbicide and authorize presumptive status for VA disability claims associated with this exposure. Presumption of service connection exists for Vietnam veterans who served in country, on land and inland waterways. Enactment of this legislation will bring a degree of justice to tens of thousands of Navy personnel who have been denied service connection by the VA since 2002. FRA also wants to thank Sen. Kirsten Gillibrand (NY) for sponsoring the Senate bill last year. We also want to thank the 221 House sponsors of the current legislation and the 330 House co-sponsors, and 53 Senate co-sponsors from last year.

If the bill is enacted these service members will no longer have to prove direct exposure to Agent Orange, and they will receive expedited consideration for VA benefits if they are afflicted with any of the health conditions associated with exposure to this defoliant. From 1964-1975 more than 500,000 service members were deployed off the coast of Vietnam and may have been exposed to Agent Orange, a herbicide used in Vietnam. Past VA policy (1991-2001) allowed service members to file claims if they received the Vietnam Service Medal or Vietnam Campaign Medal. But VA implemented a “boots on the ground” limitation on obtaining an Agent Orange presumption connection.

The herbicide was used to destroy foliage on river shore used by the Viet Cong to hide in and shoot at ships passing by. The chemical got into rivers that ran out to sea. Ships used water for bathing and drinking. It has been proven that desalinization process for water intensified toxicity of the small amounts of herbicide in water.

Mental Health/Suicide

The association was concerned to hear that the VA did not spend all its appropriated money to combat suicide in FY 2018. Secretary Wilkie said in testimony before the House Appropriations, Military Construction and Veterans Affairs Subcommittee on February 26, 2019 that the three biggest challenges for VA are: Mental Health, Suicide and veteran homelessness. The VA reports that 20 veterans a day commit suicide. Because of this statistic FRA gives this issue a high priority. The VA Secretary noted that 14 out of the 20 veterans who die by suicide are not in the VA health care system. FRA believes that effective mental health care for veterans is of paramount importance to reducing VA suicide. FRA applauds the House passing the FRA-supported “Veterans' Access to Child Care Act” (H.R. 840), introduced by Rep. Julia Brownley (CA), that would make VA's pilot program for child care a permanent program at VA for veterans who are receiving regular mental health services and other intensive health care services.

from VA. The Association believes that improved access to mental health care will reduce veteran suicide.

Association last year welcomed President Donald Trump's Executive Order titled, "Supporting Our Veterans during Their Transition from Uniformed Service to Civilian Life." The Order directs the Departments of Defense (DoD), Veterans Affairs (VA) and Homeland Security (DHS) to develop a plan to ensure that all new veterans receive mental health care for at least one year following their separation from service.

The three agencies were directed to work together to develop a joint action plan to ensure that new veterans who currently do not qualify for enrollment in healthcare — primarily due to lack of verified service connection related to the medical issue at hand — will receive treatment and access to services for mental health care for one year following their separation from service.

The DoD, VA and DHS have expanded mental health programs and other resources for new veterans for a year following departure from uniformed service, including eliminating prior time limits and:

- Expanding peer community outreach and group sessions in the VA Whole Health initiative from 18 Whole Health Flagship facilities to all facilities. Whole Health includes wellness and establishing individual health goals;
- Extending the DoD's "Be There Peer Support Call and Outreach Center" services to provide peer support for veterans in the year following separation from service; and
- Expanding the DoD's Military One Source, which offers resources to active duty members, to include services to separating service members to one year beyond separation.

FRA's 2019 legislative agenda includes ensuring adequate funding for DoD and VA health care resource sharing in delivering seamless, cost effective, quality services to personnel wounded in combat and other veterans and their families. This Executive Order has provided clear guidance to further ensure our veterans and their families know that we are focusing on ways to improve their ability to move forward and achieve their goals in life after service.

VA Choice Reform

FRA appreciates both the House and Senate Veterans Affairs Committees holding a joint oversight hearing on the VA's implementation VA MISSION Act. The VA MISSION Act (S. 2372) was signed into law by President Trump on June 6, 2018 (P. L. 115-182). The Independent Budget (IB) for Veterans Service Organizations (VSO) determined that the implementation of the VA MISSION Act (P.L. 115-182) rises above every other policy priority

for the next two years (116th Congress). FRA is a supporter of the IB and believes the VA's first priority must be to ensure all veterans, currently waiting for treatment, are provided timely access to care. The IB is co-authored by Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars (VFW). The IB has served as a guide for funding the Department of Veterans Affairs (VA) for 32 years.

In FRA online survey of veterans (January/February 2019) found that more than 88 percent see the quality of VA healthcare as "Very Important" (the highest rating), and more than 76 percent see access to VA health care benefits as "Very Important."

The Act will consolidate VA's existing community care programs into one cohesive program. It would modernize VA's medical claims processing system to ensure that community providers can expect to be paid on time for the care they provide to veterans on the VA's behalf. It would further require the VA to conduct periodic local capacity and market assessments. These would identify how gaps in care can be addressed through improvements to both internal and external capacity, standardize rates the VA pays to community providers and authorize the VA to enter into provider agreements for needed care, when contracts are not achievable.

Caregiver Expansion

The VA MISSION Act mentioned above also expands the VA Caregiver program to include all catastrophically disabled veterans. The previous caregiver law only applied to veterans disabled or wounded on or after September 11, 2001. This expansion was part of FRA's 2018 Legislative Agenda. The program will provide a monthly stipend to caregivers, and health care benefits for the caregiver. The new law will provide training for caregivers, and up to 30 days of respite care.

A 2014 RAND study commissioned by the Elizabeth Dole Foundation estimates the services these caregivers provide save our nation \$13.6 billion annually, yet these caregivers too often pay a price, suffering physical and emotional stress and illnesses; difficulty maintaining employment; financial, legal and family strains; and isolation.

These military caregivers shoulder the everyday responsibilities of providing care to those who suffered the emotional and physical tolls of war. These dedicated individuals make many sacrifices to care for their loved ones, and they deserve our support.

Post 911 GI Bill

The VA has had difficulty paying housing benefits under the Post-911 GI Bill in a timely manner. Many student veterans did not get their housing stipends for September and October last year. The VA claims the problem currently stems from an IT problem caused by changes to the

law when President Trump signed the Forever GI Act in 2017. New standards for calculating housing stipends were to be implemented on August 1, 2018, but it caused “severe critical errors” during testing that “resulted in incorrect payments.”

The agency claims that in some cases a few veterans have been paid too much but most have received too little or nothing at all. The VA is as late as two months on payments, forcing potentially thousands of former service members into financial difficulty. One frustrated student veteran said “You can count on us to serve, but we can’t count on the VA to make a deadline.”

FRA was thankful that Congress passed and the President signed into law the Servicemembers Improved Transition Through Reforms for Ensuring Progress (SIT-REP) Act (S.3777) sponsored by Sens. Mark Boozman (Ark.) and Elizabeth Warren (Mass.). The bill would ensure student veterans are not forced to endure additional financial burdens and are not denied access to school facilities due to delayed processing of G.I. Bill benefit payments. This legislation will do the following:

- Prohibit a college, university, or training program from adopting a policy in which it imposes a late fee on eligible student veterans, denies them access to school facilities (such as classrooms and libraries); or requires them to take out additional loans due to a delayed G.I. Bill benefit payment from the VA to the school;
- In the event of a delay by the VA in issuing a G.I. Bill benefit payment directly to a school, it prohibits the school from imposing late fees on student veterans and denying them access to school facilities for up to 90 days after the school certifies tuition and fees. This provision would apply only to benefits that are paid directly to the school;
- Require the VA to distribute G.I. Bill payments to the school within 60 days from when the school certifies tuition and fees for the student;
- Mandate a report from the VA to Congress twice a year with a summary of any cases in which delayed G.I. Bill disbursements occurred and an explanation for the delays.

FRA will monitor the implementation of this legislation and support sufficient funding for technical execution of all provisions of the ‘Forever GI Bill’. The Association will work to improve education benefit programs for veterans, and survivors of disabled or deceased veterans.

Veterans Health Care Reform

Veteran’s health care includes significant challenges. “For example, an estimated 25% of veterans are diabetic; nearly triple the national average of 9.4%. The Veterans Health Administration reports that military veterans also are more likely to be diagnosed with chronic conditions associated with diabetes, including hypertension, chronic obstructive pulmonary

disease (COPD) and heart disease.”² According to numerous sources 30 percent of all VA medical appointments are now held in the community rather than in VA medical facilities. The law now allows authorized veterans to access “walk-in care” a limited number of times each year at clinics with VA contracts.

VA is also working to expand and improve telehealth programs targeted at rural and underserved areas of the country. VA is developing a Request for Proposal (RFP) for provider networks that could be used with VA choice programs. VA is also doing market area assessments of capacity to develop integrated networks. The VA MISSION Act requires completion by August 1, 2019.

Appeals Process Reform

The VA has begun implementing the FRA-supported Veterans Appeals Improvement and Modernization Act (H.R. 2288 – Public Law 115-55) that was enacted in August of 2017. The enacted law sponsored by Rep. Mike Bost (IL), created three “lanes” for veterans’ appeals:

- Local Higher Level Review Lane where an adjudicator reviews the same evidence considered by the original claims processor;
- New Evidence Lane where the veteran could submit new evidence for review and have a hearing; and
- Board Lane where jurisdiction for the appeal would transfer immediately to the Board of Veterans’ Appeals.

The lanes were established November 1, 2018. It would also allow some veterans, already going through the appeals process, to opt into the new system. FRA is thankful for the House and Senate committees oversight hearings that kept pressure on the VA bureaucracy to implement the law in a timely manner.

The new law provides the VA Secretary the authority to test the new system prior to full implementation and would allow some veterans already going through the appeals process to opt into the new system. It would also require VA to provide a comprehensive plan for processing legacy appeals (appeals filed before the effective date of the bill). “The Modernization Act is the most significant statutory change affecting VA disability compensation appeals in decades.”³

VA appeals backlog in 2013, some veterans had waited years for a decision and more than 610,000 claims remained unfinished. To tackle the backlog -- defined as cases that weren't decided within 125 days -- the VA hired new employees, instituted mandatory overtime and introduced new processing systems. Still, the problem persisted with an average wait time for a

² Express Script Inc. e-newsletter 11/9/18

³ Testimony statement, Thomas Bowman, VA Deputy Secretary submitted for HVAC Jan. 30, 2018 hearing

decision reaching up to three years and the number of backlogged appeals climbing to roughly 300,000 by 2017. That is when AMA was enacted.

The VA announced December 2018 that President Trump approved the appointment of four new Veterans Law Judges to VA's Board of Veterans' Appeals.

"Bringing on additional judges means the Board will be better staffed to conduct hearings and decide appeals properly in a timely manner," said VA Secretary Robert Wilkie. "Combined with procedural changes under the Veterans Appeals Improvement and Modernization Act and the hiring of more than 200 additional board attorneys, this translates into better and faster service for veterans."

In fiscal year 2018, the Board issued an historic 85,288 decisions to veterans—61.6 percent more than 2017. Expanding the roster of Veterans Law Judges will allow the Board to continue issuing more decisions for veterans, as VA prepares for full implementation of the AMA. This law transforms a complex appeals process into one that is simplified, timely and transparent by providing veterans with increased choice and control. The AMA was legislation supported by FRA and was scheduled to go into effect February 2019.

Disability Claims Backlog

FRA urges Congress to pass legislation that requires VA be held accountable for achieving the VA's stated goal to achieve an operational state for VA in which no claim is pending over 125 days and all claims have an accuracy rate of 98 percent or higher. As of February 16, 2019 there are 349,681 claims pending and of those 79,681 pending disability claims that are backlogged (pending over 125 days) and that claims adjudication accuracy is over 95 percent.⁴ Based on information from last year the backlog claims has not changed much (Nearly 78,600 claims) but accuracy has improved from a year ago (83 percent). The backlog peaked at about 611,000 cases in March 2013 and was down as low as 70,000 cases in fall of 2015, when VA officials announced that zeroing out the backlog completely was likely impossible and could unnecessarily rush some cases.

Burn Pits Accountability

Reps. Tulsi Gabbard (Hi) and Brian Mast (Fla.), Iraq and Afghanistan veterans, respectively and Sen. Klobuchar (MN) have introduced the FRA-supported "Burn Pits Accountability Act" (H.R. 663/S.191). The legislation directs DoD to provide service members in Iraq and Afghanistan to

⁴ Veterans Benefits Administration Reports, Feb. 19, 2019, Department of Veterans Affairs

have periodic health assessments during deployment and during military separations an evaluation of whether or not a service member has been exposed to open burn pits or toxic airborne chemicals. If they report being exposed, they will be enrolled in the Burn Pit Registry unless they opt out.

The bill seeks to address the widespread exposures of service members to airborne toxins from burn pits during post-9/11 deployments, a problem experienced by many veterans who served in Iraq and Afghanistan. These toxic exposures could potentially impact millions, and many post-9/11 veterans believe this could be "their Agent Orange issue of their generation."

The VA estimates 3.5 million veterans are eligible to register in the VA's Airborne Hazards and Open Burn Pit Registry, which tracks exposures to airborne toxins. Veterans have expressed deep concerns that these exposures could result in cancer, respiratory issues, and birth defects.

Oversight of VA IT

The Association believes Congressional oversight of ongoing implementation of VA technology upgrades is vital to ensuring improvements to the system. FRA wants to ensure adequate funding for Department of Defense (DoD) and Department of Veterans' Affairs (VA) health care resource sharing in delivering seamless, cost effective, quality services to personnel wounded in combat and other veterans and their families.

VA Secretary Shulkin in June 2017 announced that the VA will dramatically reform his agency's Electronic Health Record (EHR) system by replacing the old antiquated system with same system used by the DoD. This change is a shift from the VA's previous plan to develop its own system to digitize records. It will bring the agencies closer to sharing veterans' health information in an effort to solve a problem that has plagued the two departments for decades.

Some members of Congress have expressed concern about the cost. While the EHR modernization effort is necessary, it is very expensive. The most recent estimate is more than \$16 billion over 10 years. In addition some legislators have expressed concern that full implementation could take as long as a decade. A Senator at an oversight hearing (Sen. MilCon/VA-Feb. 2019) expressed concern that the system could be out-of-date by the time it is fully implemented. The cost and the long time for implementation notwithstanding FRA believes there is tremendous opportunity with the two departments using the same EHR.

Women's Veterans Issues

FRA welcomes Rep. Mark Takano (Calif.), the new chairman of the House Veterans' Affairs Committee, creating a new congressional task force to address barriers that women veterans face

when trying to obtain Department of Veterans Affairs (VA) benefits and health care. The Association works to increase access to gender-specific medical and mental health care to meet unique needs of women service members and transitioning women veterans. Congresswoman Julia Brownley (Calif.) has been selected to serve as Chairman of the task force.

Today, women serve in the Reserve Component at a rate of 17 percent which is 3 percent higher than that of the active duty military. Women are serving in combat conditions right alongside their male counterparts, which raises a whole new set of issues for these veterans. That is why FRA supports the “Deborah Sampson Act” that was recently introduced in the Senate, sponsored by Sens. John Boozman (Ark.), and Jon Tester (Mt.) and introduced in the House, sponsored by Rep. Julia Brownley (CA) that seeks to improve and expand VA's programs and services for women veterans. Major provisions of the bill include the following:

- Empowers women veterans by expanding peer-to-peer counseling, group counseling and call centers for women veterans;
- Improves the quality of care for infant children of women veterans by increasing the number of days of maternity care VA facilities can provide and authorizing medically-necessary transportation for newborns;
- Eliminates barriers to care by increasing the number of gender-specific providers and coordinators in VA facilities, training clinicians, and retrofitting VA facilities to enhance privacy and improve the environment of care for women veterans;
- Provides support services for women veterans seeking legal assistance, and authorizes additional grants for organizations supporting low-income women veterans; and
- Improves the collection and analysis of data regarding women veterans, and expands outreach by centralizing all information for women veterans in one easily accessible place on the VA website.

Further FRA is supporting The “Servicemember and Veterans' Empowerment and Support Act” that expands the definition of Military Sexual Trauma to ensure service members and veterans who experience online sexual harassment can access VA counseling and benefits. It also codifies a lower burden of proof so more survivors are eligible for trauma and mental health care related to MST, even if they didn't feel comfortable reporting the event to their chain of command while in service.

The Association is thankful to Senators Jon Tester (Mt.), Lisa Murkowski (Alaska) and Congresswoman Chellie Pingree (Me) for introducing their bipartisan bill to improve resources and care for survivors of military sexual trauma (MST).

Homeless Veterans

The Department of Housing and Urban Development (HUD) recently released its 2018 annual report on homelessness. HUD's Annual Homeless Assessment Report finds the total number of reported veterans experiencing homelessness in 2018 decreased 5.4 percent compared to the previous year, falling to nearly half of the number of homeless veterans reported in 2010. Each year, thousands of local communities around the country conduct one-night 'Point-in-Time' estimates of the number of persons experiencing homelessness—in emergency shelters, transitional housing programs and in unsheltered locations. The estimate finds 37,878 veterans experienced homelessness in January 2018, compared to 40,020 reported in January 2017.

In announcing the latest annual estimate, HUD Secretary Ben Carson and U.S. Department of Veteran Affairs (VA) Secretary Robert Wilkie noted that all local communities are reporting reductions in the number of veterans in their shelter systems and on their streets. "We owe it to our veterans to make certain they have a place to call home," said HUD Secretary Carson. "We've made great strides in our efforts to end veteran homelessness, but we still have a lot of work to do to ensure those who wore our nation's uniform have access to stable housing."

"The reduction in homelessness among veterans announced today shows that the strategies we are using to help the most vulnerable veterans become stably housed are working," said VA Secretary Robert Wilkie. "This is good news for all veterans."

In 2010 the Department of Veterans Affairs (VA) established a goal of eliminating veteran's homelessness by 2015. That goal has not been achieved. The Department of Housing and Urban Development (HUD) and VA have a wide range of programs that prevent and end homelessness among veterans, including health care, housing solutions, job training and education. VA, the Department of Labor, and HUD programs for homeless veterans have reduced homelessness. Witnesses at the hearing agreed that such programs are highly successful in working toward a "functional zero" and in assuring veterans who overcome homelessness do not become homeless again.

Increase Veterans Burial Benefits

The VA pays a higher level of burial benefits upon the death of a veteran who dies from a service-connected illness or disability and lesser burial benefits upon the death of a wartime veteran who dies from a non-service-connected illness or disability. The current VA burial expense payment is \$2,000 for a service-connected death and \$300 for a non-service connected death, along with a \$700 plot allowance. At its inception, the payout covered 72 percent of the funeral costs for a service-connected death, 22 percent for a non-service-connected death and 54 percent of the cost of a burial plot. Due to the dramatic increase in private sector funeral expenses, this benefit has been seriously eroded over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they

covered in 1973 when the VA first started paying burial benefits. The VA should provide the resources needed to meet increasing private-sector costs of burial.

Congress should increase the plot allowance for all eligible veterans and expand the eligibility for the plot allowance for all veterans who might be eligible for burial in a national cemetery, not just those who served during wartime.

Conclusion

In closing, allow me again to express the sincere appreciation of the Association's membership for all that you and the members of both of the House and Senate Veterans' Affairs Committees and your outstanding staffs do for our Nation's veterans.

Our leadership and Legislative Team stand ready to work with the Committees and their staffs to improve benefits for all veterans who have served this great Nation.

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**Robert Washington Sr.
FRA National President**

In September of 2018, Robert Washington Sr., of the Navy Department (Branch 181) won election to National President (NP) with Donna M. Jansky, of North Shore (Branch 31) securing the National Vice President position at the Fleet Reserve Association National Convention in San Antonio, TX. Washington is the first African-American to hold the NP position, and Jansky is the first woman to hold the NVP position. Both Shipmates have been very active with the association for decades. Washington was part of the National Headquarters staff from 1998-2017 and has been a member of the association since February 1988. His last position with FRA was Director Outreach Coordination/Legislative Program Healthcare Advisor.

He is a retired Senior Chief Yeoman. Before joining the FRA staff in 1998 he was the Navy's Senior Enlisted Advisor for the Defense Information Systems Agency in Arlington, Virginia. He enlisted in the United States Navy in December 1971, and served continuously until his transfer to the Fleet Reserve. During his career, he served aboard the *USS STRONG* (DD-758), *USS SIMONLAKE* (AS-33), HS-17 onboard *USS CORAL SEA* (CV-43), *USS MOUNT WHITNEY* (LCC-20), and was embarked in COMCARGRU FOUR staff, Norfolk, Virginia. He also served at the following shore duty command: Staff MINERON Twelve, Charleston, South Carolina; PSD, NTC, Orlando, Florida; PSD Crystal City, Arlington, Virginia; Bureau of Naval Personnel, Washington, DC; DISA, Arlington, Virginia. He is also a graduate of the Navy Senior Enlisted Academy, Newport, Rhode Island.

As Outreach Manager for the Association he was responsible for enhancing communications and awareness of the association to increase membership, and establishing contacts and build ongoing working relationships with Fleet, Force, CNO-Directed, Command and/or other active and reserve Master Chiefs and Sergeants Majors. As the Legislative Program Healthcare Advisor for FRA, he worked hand-in-hand with The Military Coalition (TMC) and Congress on healthcare issues involving active duty members, reservists, and military retirees and their family members. He tracked Healthcare policies and legislation and spoke at many active duty and retiree seminars. He also served as cochairman of TMC's Health Care Committee, and served on the Department of Defense Healthcare Initiatives Review Panel, and former chairman of the DoD Uniformed Formulary Beneficiary Advisory Panel.

He is a Past FRA Regional President East Coast Region, past President of Navy Department Branch 181, Fleet Reserve Association, Arlington, Virginia, and Past Chairman of the FRA Central Liaison Committee for the Northern Capitol Region. He was born in Charleston, South Carolina, and was raised and educated in that city. He and his wife, Debra, currently reside in Oxon Hill, Maryland. They have two sons and one daughter.

Fleet Reserve Association (FRA) Testimony Summary

- FRA applauds the ruling of *Procopio v Wilkie*, and advocates for the passage of H.R. 299 in addition to the court ruling as a means of “providing justice” for Blue Water veterans.
- FRA supported the President’s executive order from last year, “Supporting Our Veterans during Their Transition from Uniformed Service to Civilian Life,” which directed VA, DOD, and DHS to develop a joint plan to ensure that all veterans, regardless of discharge status, had access to mental health care for at least one year following their separation from service.
- FRA is concerned that VA did not spend all the money appropriated in FY18 to combat veteran suicide.
- FRA supports the implementation of the VA MISSION Act.
- FRA will continue to monitor the implementation of the Forever G.I. Bill as per the Forever GI Bill Housing Payment Fulfillment Act of 2018 (P.L. 115-422). In their testimony FRA mistakenly refers to the SIT-REP Act, which was never passed by Congress, instead of P.L. 115-422.
- FRA supports the implementation of the Veterans Appeals Improvement and Modernization Act.
- FRA urges Congress to hold VA accountable to its goal of achieving an operational state in which no disability claim is pending for more than 125 days.
- FRA supports passage of the “Burn Pits Accountability Act” (S. 191).
- FRA believes that the Electronic Health Records Modernization process presents a great opportunity to improve the quality of service to veterans through an interoperable medical records system.
- FRA supports passage of the “Deborah Sampson Act” and the “Servicemember and Veterans’ Empowerment and Support Act.”
- FRA supports VA-HUD cooperation in working to reduce the homeless veteran population.
- FRA supports an increase in the plot allowance and expanding eligibility for burial in national cemeteries to all veterans, not just wartime veterans.



Gold Star Wives of America, Inc.

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Statement of

Gold Star Wives of America, Inc.

Before the Joint Senate and House Committees on

Veterans Affairs Hearing

March 12, 2019

Presented By

Crystal Wenum

National President

Gold Star Wives of America, Inc.

"With malice toward none; with charity for all; with firmness in the right, as God gives us to see right, let us strive to finish the work we are in; to bind up the nation's wounds, to care for him who have borne the battle, his widow and his orphan."

... President Abraham Lincoln, Second Inaugural Address, March 4, 1865

Introduction

Chairman Senator Isakson (R-GA), Chairman Representative Takano (D-CA), Ranking Member Senator Tester (D-MT), Ranking Member Representative Roe (R-TN), and distinguished members of both the Senate and House Committees on Veterans Affairs, I am pleased to be here today to testify on behalf of Gold Star Wives of America, Inc. (GSW) to share our legislative priorities.

My name is Crystal Wenum and I am the widow of SSGT James O Wenum, a Vietnam veteran who served during the Tet Offensive. He died on May 8, 1982 after suffering a massive heart attack while on duty with his US Army Reserve Unit and died 3 days later leaving me to raise our 5 and 3-year old children. His death was determined to be service related 2 years later and I joined Gold Star Wives that year. But in addition to being a Gold Star Wife, I am a Gold Star Daughter. My father was KIA at the Chosin Reservoir in Korea on November 29, 1950. My mother was 6 months pregnant with me and had a 1-year old son at the time. My mother joined Gold Star Wives in 1951 and I have literally grown up with this wonderful organization. I have remained active with Gold Star Wives and I am proud to now be National President of Gold Star Wives of America, Inc.

I knew a lot of the past presidents and members who worked so hard walking the halls of Congress to get the benefits that we have today and I am eternally grateful for all their hard work and sacrifices that they made to bring us where we are today. I went to college using my Chapter 35 benefits and was able to get a job as an auditor with the state of Minnesota so that when my husband died, I was not plunged into poverty like so many of my fellow Gold Star surviving spouses. My salary plus my DIC and Social Security allowed me to raise our children modestly. I was even able to save enough to go to many of the Gold Star Wives National Conventions. My children say they had some interesting vacations going to them.

Gold Star Wives of America, Inc., (GSW) is grateful for all the public laws that have been passed in the years since 1946. These laws provide much needed benefits for surviving spouses and children of our military service members. GSW thanks you for your continued support of education for post 9-11 survivors with the Fry Scholarship. With the passage of the Forever GI Bill in 2017, survivors no longer have a 15-year time limit to use education benefits and are now eligible for the Yellow Ribbon Program. GSW appreciated the work that was done in the last Congress to extend the Special Survivor Indemnity Allowance (SSIA) at the rate of \$310 per month indefinitely, plus cost of living adjustment (COLA).

The mission of the GSW organization is to provide much needed moral support during a surviving spouse's lifelong journey through grief and recovery from the loss of their service member and to protect the needed benefits of the families they left behind. GSW brings awareness to Congress, the public, and the military community of the inequities that exist in benefits provided to surviving spouses and their children. We are a non-profit organization and receive no federal grants.

Our testimony will be addressing some of the inequities and concerns that currently exist:

1) Dependency and Indemnity Compensation (DIC), the flat monthly rate (\$1319.04) has not been increased since 1993 except for Cost of Living Adjustments (COLA).

2) Survivor Benefit Plan (SBP)/DIC offset in which a law requires a \$1.00 reduction in a Department of Defense (DOD) SBP for each \$1.00 received from the Department of Veteran Affairs (VA) DIC.

3) Change in the Gold Star Wives of America, Inc. Federal Charter

4) Eliminate the Remarriage Penalty for Young Surviving Spouses

5) Other Concerns

Dependency and Indemnity Compensation (DIC)

“...to care for him who have borne the battle, and for his widow and orphan...”

These words from Abraham Lincoln’s Second Inaugural Address in 1865 succinctly state the sacred promise our country has made to our veterans and survivors. Congress has always had an important role in ensuring that this promise is kept. This promise began with the Continental Congress in 1780 when Congressional action created survivor benefits for certain Revolutionary War survivors. The need to keep this promise to care for the veterans and their survivors is critical.

In 1956, the death compensation was provided to survivors regardless of income. The amount was determined by wartime or peacetime service. Compensation was amended again, in 1969, by Congress with a fixed rate of compensation assigned to each rank. In 1993, Congress established PL 102-568, which resulted in two types of DIC. The first is referred to as rank based DIC determined by pay grade of the deceased military service member/veteran. Rank based DIC is in the process of being phased out through attrition. The second type of DIC is flat rate DIC. All surviving spouses whose military spouse died on or after January 1, 1993 receive the monthly flat rate DIC regardless of rank.

The Fiscal Year, 2017 Annual Benefits Report issued by the VA updated in September 2018, states there are 394,028 surviving spouses who receive DIC. The largest group of DIC recipients is the surviving spouses from World War II, the Korean Conflict, and Vietnam Veterans. Over 90% of these surviving spouses are over the age of 57, with 40% over the age of 75. Most are well past their most productive earning years. Prior to the Vietnam War, society encouraged women to work in the home, maintaining the house, and raising children. After the Vietnam War, many became the caregivers for their disabled veteran spouses.

The Cost of Living Adjustment (COLA) increases have been the only changes in DIC since the flat rate was implemented in 1993. When DIC is compared to payments to surviving spouses of other federal employees, DIC lags behind by almost 12%. The current DIC flat rate for a surviving spouse is \$1,319.04 per month. This is 43% of the disability compensation rate for a fully disabled single veteran whose rate is \$3,057.13 per month.

Since 1993, surviving spouses of military Veterans are finding themselves falling further and further behind in meeting their financial obligations from month to month. Many surviving spouses of WWII, Korea, and Vietnam era wars are receiving only DIC; some receive DIC and minimum Social Security benefits. These DIC recipients struggle monthly with their budget of \$1,319.04, juggling bills to meet the rising costs in health and dental insurance, housing, utilities, food, clothing and other personal living expenses. This scenario leads too often to homelessness,

a plight we do not wish to befall anyone, and least of all the surviving spouses of our military Veterans.

Husband passed away in 2003 from a disease of the Vietnam War (Agent Orange). He was a Helicopter Gunship Pilot in the Army. They have 4 children. Between food and so many hospital and doctor bills for one of the siblings who has a rare cancer. This GSW couldn't make financial ends meet. She lost her home because the bills piled up and she fell behind. Between the Red Cross and another Massachusetts organization they helped place her in another home and offset some of the hospital bills associated with her son. (Boston, MA)

A GSW husband was killed in action (KIA) – Vietnam. She has had a very hard time making ends meet. She has received monies along the way from various support organizations. Most recently she desperately needed dentures, but the total monies received just wasn't enough. She continues to suffer with only partial dentures but desperately needs much more dental work – her budget just won't allow her to even go on a payment plan. (So. Boston, MA)

"I was recently approved for my DIC. I am disabled needing help for most daily functions. They approved me for aide and attendance but the amount is about \$300.00 per month. Added to my DIC payment I still can't afford to hire a caretaker if I want to eat and pay my bills. I get 1/10 of what my husband received and practically none of his benefits. I saved the VA dollars because I cared for him at home for 6 1/2 years and my reward was poverty." (State of Arkansas).

"My story starts when my husband got 100% permanent and total disability for PTSD. I told him I would quit my job and join him in his retirement. Little did we know that I would become his caregiver until he died 7 years later. Not only did he have PTSD, but many other service related medical issues. I stayed by his side for every hospital stay, procedure, surgeries, doctor appointments, and dialysis. I was happy to take care of him and not a day went by that he didn't express his gratitude. We were able to live comfortably thank goodness! Now over a year since he passed I realize I cannot make ends meet with DIC and his pension, which is reduced by 1/3. In all, I receive \$20,000 less per year now. I still have the same bills. It's really hard. I don't want to have to sell my farm. Please consider the proposed increase for DIC recipients."

"The biggest problem with DIC is that my rent takes over half of it, and as we all know, rent goes up every year. I'm on pins and needles thinking about that because I know my rent will go up in November and I'm pretty sure I'm not going to be able to afford it." (A GSW and also a veteran from PA, states that her husband was a Vietnam veteran. His death was Agent Orange related.)

It is incumbent upon Congress to take action to rectify this inequity by increasing the current amount of DIC paid to a level comparable to other federal employees. This would be in keeping

with the promise our country made to its veterans and survivors. **Our widows from WWII, Korea, and The Vietnam era wars are now in their sixties through nineties. These are the survivors who need the increase the most.**

We are looking forward to the introduction of bills in the Senate and House to increase the DIC from 43% (\$1319.04) to 55% (\$1681.42) of a single 100% disabled veterans' compensation (currently \$3057.13). Bringing DIC compensation to 55% would provide parity with other Federal survivor programs.

Survivor Benefit Plan/Dependency Indemnity Compensation Offset (SBP/DIC Offset)

In 1972, Congress created the Survivor Benefit Plan (SBP) for retiring service members who may select up to 55% of their retirement pay towards SBP. This would ensure that their surviving spouse has income after their death. In 2001, further changes expanded the program to include the surviving spouses and/or eligible children of all active duty deaths classified as in the line of duty (LOD) including reserve members on active duty for annual training days. In 2013, SBP eligibility was extended to deaths classified in LOD of inactive duty training deaths.

While GSW is grateful for the changes that have been made to the military's SBP, it is essential to know and acknowledge that many active duty surviving spouses do not meet the qualifications necessary to receive full SBP. Over 40,000 military surviving spouses receive no SBP at all. The reason for this is that their service member spouse, who died in the LOD, did not live long enough to achieve the necessary rank and time in service to overcome the DIC offset. The average monthly DIC offset to SBP is \$915.00 per the latest DOD Statistical Report of the Military Retirement System Fiscal Year 2017. **The spouses, subject to the SBP/DIC offset, only receive the portion of the SBP that exceeds the DIC offset.**

There is no DIC offset to children receiving SBP. Therefore, many of the young surviving spouses sign the SBP benefit over to their children. The children lose this benefit when they reach the age of majority. The surviving spouse forever forfeits their rights to this benefit. These are the sacrifices a parent should not have to make. If the elimination of the SBP/DIC offset occurs, then the surviving spouses should have the option to reclaim the SBP.

For a surviving spouse to receive their SBP benefits in full, they must remarry at or after the age of 57. Any SBP premiums paid to the surviving spouse upon their spouse's death must be paid back upon remarriage in order to receive the full SBP benefits.

The SBP/DIC offset also affects the surviving spouses of those who die in retirement from a service connected cause and made a decision in good faith to purchase the SBP plan for their spouses. If they die as a result of their service connected disability, their surviving spouse's SBP would be reduced dollar for dollar by DIC.

The National Defense Authorization Act (NDAA) for FY 2004 permitted certain veterans who are eligible for military retired pay and for veterans' disability compensation, to receive concurrent payment of each without an offset. As you are aware, the SBP/DIC offset is a concurrent receipt issue.

There are two different survivor benefits. The SBP is a purchased annuities benefit, or type of insurance benefit. This is purchased out-of-pocket by military retirees for their surviving spouses. The SBP is our service members' earned benefit, not an entitlement received from the DOD. The other benefit is DIC. DIC received from the VA. serves as an indemnity payment for death. Since death is the ultimate disability the surviving spouses should be entitled to concurrent receipt of both SBP and DIC. **Instead SBP is offset dollar for dollar by DIC causing the surviving spouse to receive less money on a monthly basis than paid and planned for by the service member.**

The Survivor Benefit Plan (SBP), administered by the Department of Defense (DOD), pays up to 55% of a military retiree's retirement pay to the surviving spouse. Under the Civil Service Retirement System (CSRS), the surviving spouse receives 55% of the retirement benefit. In the Federal Employees Retirement System (FERS), the surviving spouse is eligible for 50% of the retirement pay plus a significant lump sum payment.

A bill, HR-553 Military Surviving Spouses Equity Act, was introduced in the House of Representatives by Representative Wilson (R-SC). We look forward to similar legislation being introduced in the United States Senate.

Change in the Gold Star Wives of America, Inc. Federal Charter

Change in the GSW Federal Charter: US Code: Title 36>Subtitle II> Part B> Section 80507, Restrictions: (b) Political Activities. The corporation, or a director or officer as such may not contribute in any political activity or in any manner attempt to influence legislation. GSW wishes to eliminate the last few words of Section 80507 (b) " or in any manner attempt to influence legislation." **Gold Star Wives are often asked by Congress to testify and they should be able to speak to legislative representatives on behalf of the organization, inline with other veteran and military service organizations.**

Eliminate The Remarriage Penalty for Young Surviving Spouses

GSW would like your assistance in changing current law that binds young surviving spouses to widowhood. Under current law, if the surviving spouse remarries before the age of 57, he/she forfeits lifesaving benefits afforded to them. After researching the complex bureaucracies that govern rules addressing surviving spouses and congressional research, GSW realized age 57 is an arbitrary age that penalizes young surviving spouses. Please remove the age limit on all available benefits for surviving spouses who remarry.

Other countries have recognized the remarriage concern brought to you today and have taken steps to alleviate the remarriage issues. For example, in 2014 the United Kingdom changed a similar law recognizing unfair treatment of surviving spouses. The Prime Minister said, "For decades the wives of fallen service members had to choose between finding new love and financial stability under a complex scheme introduced in 1975 that stopped the pensions of military widows who remarried or cohabited with someone after the death of their spouse." United Kingdom abolished the law. GSW asks that you do the same here in the United States.

Fourteen years after burying her soldier in Arlington, a young widow in Colorado has slowly put her life back together relying on the benefits afforded to her as a result of her husband's death. However, she is painfully banned to not ever being able to remarry because it would cost her the very benefits that have allowed her to sustain life. This deepens the grief and trauma caused by her loss and is unfair.

Two other young surviving spouses in Colorado have tried to go on with their lives after losing their soldiers. Recently, both have become engaged. Instead of feeling happy, they are in emotional turmoil as they scramble financially to understand its impact. They are caught in the dilemma of having to be dependent on their soon to be spouse, yet they still carry the loss, grief and burdens of their former. They will now have to live without their DIC, SBP, Tricare, known military medical providers (including behavioral health/grief services), and education. They are being placed in vulnerable situations because our government essentially is saying they now become a ward of their new spouse.

On behalf of surviving spouses, GSW respectfully requests your assistance in changing current law. In 2017, a cost analysis of this issue with the CBO that we believe is inaccurate. Ironically, this inaccurate information is being used to justify not pursuing such a bill, citing "astronomical costs." However, per the Veterans Administration, only 265 DIC awards were terminated in FY 2017 due to remarriage for a surviving spouse under the age of 57. Given that a majority of recipients are over the age of 57, the age in which they would not lose benefits if they remarried, it seems that the young surviving spouses are again unfairly penalized. This devalues surviving spouses by failing to give our issues the adequate research, data collection and attention they

deserve. Changing this law would not cost the government as the awards are already being paid. Please support that and other advocacy to keep all of surviving spouse's benefits intact regardless of marital status. To lose these benefits creates further undue burden and places surviving spouses at risk. We did not ask for our circumstances.

Other Concerns

* Being intimately familiar with the devastation of death, GSW is extremely concerned with the overwhelming number of veterans and active duty service members who died by suicide every day. Tragically, many of these people die without having sought help for common side effects of war, such as PTSD. Often, if there is no diagnosis, benefits are not afforded to the family left behind. GSW supports any effort to reduce the rate of service-connected deaths by suicide and to expedite the process for survivors to obtain the benefit they desperately need.

* Gold Star Wives thanks you for education and training options available to surviving spouses. These benefits make it possible to obtain a post-secondary education. This education allows for greater opportunities in employment in a competitive, highly educated workforce.

Survivors' and Dependents' Educational Assistance (Chapter 35) continues to be a very viable program. Eligibility is broad in scope and includes both survivors of veterans whose death is service connected and dependents of veterans whose service-connected disability is rated as total and permanent. During FY 2017, 100,275 beneficiaries utilized their Chapter 35 benefits. The number of eligible beneficiaries has steadily increased over the last five fiscal years. Chapter 35 pays a monthly allowance of \$1224 up to 45 months. Usually eligible surviving spouses have 10 years for the date of death of the veteran to use their Chapter 35 benefits. Dependent spouses have 10 years from the date of the veteran's 100% P&T rating to use their Chapter 35 benefits.

Time ran out for the dependent of a KIA Vietnam veteran before using all her Chapter 35 benefits. Her job deals with the National Historic Preservation Act with changes in technology, information and federal regulations. The ability to use her remaining months of education benefits would allow her to stay current in her profession.

The Post 9/11 GI Bill was amended to include the Marine Gunnery Sergeant John David Fry Scholarship (Fry Scholarship). While narrower in eligibility, the Fry Scholarship is an important benefit. Survivors of servicemembers who die in the line of duty are eligible for this benefit, which includes full tuition and fees, a monthly housing allowance and a books/supplies stipend. In FY 2017, 864 spouses utilized their Fry Scholarship benefits. The Forever GI Bill removed the time limit that these surviving spouses must use their Fry Scholarship benefits.

A widow of a combat Vietnam veteran who died due to Agent Orange exposure in Vietnam, returned to an Oklahoma college at age 63 to update her teaching skills. Classified as a

Senior, her 10 years to use Chapter 35 ran out. Removal of the 10-year timeframe would allow her to complete her degree.

We ask that Congress remove the 10-year delaminating date for surviving spouses, as well as dependent spouses, to use their Chapter 35 benefits so they might meet the needs of their families while completing their post-secondary education.

* Listed below are situations that GSW members face due to financial hardships.

Car company would not re-finance our vehicle in my name to lower my payment. I had to suffer through 4 years of high payments to have a way to get around. I also thought I would be homeless, but finally manage to get a modified loan to stay in my place, but interest rate is going up each year. (State of GA)

My bank, Wells Fargo, would not re-finance my home because I had lost too much income at my husband's death. (State of GA)

Chase Bank reposed my late husband's car. Sold car at auction below cost. They billed me for selling at a loss. They charged for keys and remote. I had to hire a lawyer to get help. (State of GA).

My husband was 100% disabled and I took care of him. Income went from \$3200.00 to \$1200.00 per month. I am still trying to get DIC. The VA fixed the house for him with HISA Grant but even though they say he was exposed to Agent Orange, they paid \$2000.00 on his funeral. I had to take our savings to pay \$1100.00 so without DIC I am struggling to pay bills every month. (State of GA).

The monthly benefit (DIC) really helps for widows of veterans but is not enough to live on even when added to social security benefit. It would be helpful if the monthly benefit was equal to the percentage for Federal employee benefits. Dental is needed. It would also be helpful if availability of benefits were actually relayed to veteran's spouses. (State of TN).

Toys for Veteran and Families who otherwise could not afford—Christmas time I volunteered for a local organization named "Military Friends Foundation". They had a "Veteran" and "Family" toy event. Veterans or their family member serving in the armed forces, mother's or fathers, and many Gold Star Wives and Gold Star Mothers attended this incredible event and were allowed to choose 2 large gifts (bikes, game equipment and more) as well as 3+ small stocking stuffers for each child in their household. Many of these recipients made so many comments about not being able to afford a gift for their children this Christmas due to financial constraints. The smiles and gratitude was immeasurable. They went into the holiday with much joy to be able to provide for their children when they could not. (Boston, MA).

Conclusion

Gold Star Wives of America, Inc. is appreciative for existing laws that provide vital benefits and support for surviving spouses and children of our military members who gave their lives in service for our country. It is our duty to stand together with you and ensure that President Lincoln's words still ring true, that our nation provides for the victims of her wars. We are the families that are left behind, yet another casualty of wars.

With every flag-draped casket that is flown home, another family suffers devastating loss. These brave men and women answered our Nation's call to service, believing that our Nation would properly care for their loved ones, if the ultimate sacrifice came. We honor their memories by asking for your help in rectifying the inequities we have presented. Our benefits are not 'entitlements', but have been earned through service and sacrifice that never goes away.

President John F. Kennedy said: "A nation reveals itself not only by the citizens it produces, but also by the citizens it honors, the citizens it remembers."

Again, thank you for the opportunity to testify on behalf of Gold Star Wives of America, Inc. I am available for any questions you might have.

Contributors

Misty J Brammer-Widow of Staff Sergeant Kerry J. Brammer, US Army, in line of duty, 2005
 Jeanette Early-Widow of Sergeant First Class, Howard L. Early, US Army, combat death, Vietnam, 1969
 Donna Eldridge-Widow of Colonel Gary W. (Bo) Eldridge, US Army
 Cyndie Gibson-Widow of Major Parks Gibson, US Air Force in line of duty, 2007
 Lupe MaGuire-Widow of Chief Warrant Officer John Thomas MaGuire, US Army
 Pat Collins Miller-Widow of SGT Danny J. Miller, US Army, Agent Orange, disability death, 2008

Biography for Crystal Wenum, Gold Star Wives of America, Inc.



My name is Crystal Wenum and I am the widow of SSGT James O Wenum, a Vietnam veteran who served during the Tet Offensive. He died on May 8, 1982 after suffering a massive heart attack while on duty with his US Army Reserve Unit and died 3 days later leaving me to raise our 5 and 3 year old children. His death was determined to be service related 2 years later and I joined Gold Star Wives that year. But in addition to being a Gold Star Wife, I am a Gold Star Daughter. My father was KIA at the Chosin Reservoir in Korea on November 29, 1950. My mother was 6 months pregnant with me and had a 1-year old son at the time. My mother joined Gold Star Wives in 1951 and I have literally grown up with this wonderful organization. I have remained active with Gold Star Wives and I am proud to now be National President of Gold Star Wives.

I knew a lot of the past presidents and members who worked so hard walking the halls of Congress to get the benefits that we have today and I am eternally grateful for all their hard work and sacrifices that they made to bring us where we are today. I went to college using my Chapter 35 benefits and was able to get a job as an auditor with the state of Minnesota so that when my husband died, I was not plunged into poverty like so many of my fellow Gold Star surviving spouses are. My salary plus my DIC and Social Security allowed me to raise our children modestly. I was even able to save enough to go to many of the Gold Star Wives National Conventions. My children say they had some interesting vacations going to them.

As stated earlier I have been an active member of Gold Star Wives since joining in 1984. I have held many positions within GSW including being a chapter president, a member of the board of directors and now currently serving as the National President. I feel very honored to serve this wonderful organization and plan on continuing to serve it into the future.

Gold Star Wives of America (GSW) Testimony Summary

- GSW is concerned that, with the exception of annual COLAs, the Dependency and Indemnity Compensation (DIC) flat monthly rate has not been increased since 1993. It currently sits at \$1,319.04 per month, or 43% of the compensation received by a single 100% disabled veteran (\$3,057.13 per month). GSW would like to see the DIC flat monthly rate raised to \$1,681.42, or 55% of the compensation received by a single 100% disabled veteran.
- GSW supports H.R. 553, the “Military Surviving Spouses Equity Act.” This bill would amend title 10, U.S.C., to repeal the requirement for reduction of survivor annuities under the Survivor Benefit Plan for military surviving spouses to offset the receipt of veterans dependency and indemnity compensation.
- GSW wants to remove current restrictions on benefits for surviving spouses that remarry before the age of 57. Currently, if a surviving spouse younger than 57 remarries, they forfeit all benefits afforded to them as surviving spouses. GSW wants this penalty eliminated.
- In general, GSW continues to advocate for increased benefits for surviving spouses. They are also concerned with mental health and veteran suicide issues.



**TESTIMONY
PRESENTED BY**

**Thomas A. Zampieri Ph.D.
BVA NATIONAL PRESIDENT**

**BEFORE A JOINT SESSION OF THE
HOUSE AND SENATE COMMITTEES
ON VETERANS AFFAIRS**



MARCH 12, 2019

INTRODUCTION

Chairman Isakson, Chairman Takano, Ranking Members Tester and Roe, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this opportunity to present our legislative priorities for 2019. BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. National Blind Veterans Day on March 28 marks the 74th anniversary of our founding.

It is our hope that the 116th Congress will take action in the year ahead to address the following issues:

- The need for Congress to ensure that VA's implementation of benefits for caregivers for catastrophically disabled veterans from previous war eras, is appropriate and timely, and insure that the eligibility criteria employed by VA to determine who is eligible for such benefits do not inadvertently preclude caregivers for blinded veterans from receiving assistance;
- The need for continued Congressional oversight of VA's compliance with the Rehabilitation Act's effective communication requirements;
- The need for members of the Veterans' Affairs Committees to support an appropriation of \$20 million for the DoD Vision Research Program in FY 2020 in order to strengthen the only research program in the nation that focuses on prevention and treatment of combat-related eye injuries and visual dysfunction;
- The need for Congress to conduct oversight of the implementation of the Vision Center of Excellence, joint Defense Veterans Eye Injury Vision Registry; as well as the hearing Center of Excellence;
- The need for Congress to pass H.R. 1092, the bipartisan bill to improve resources and care for survivors of military sexual trauma (MST), by U.S. Senators Jon Tester (D-Mont.), Lisa Murkowski (R-Alaska) and Congresswoman Chellie Pingree (D-Maine).
- The need for the Veterans' Affairs Committees to support changing specially adapted housing grant eligibility criteria to enable blinded veterans to qualify based on their blindness alone;
- The need for members of the veterans' affairs committees to support reinstatement of eligibility for blinded veterans to use special mode transportation provided by the VA and its contractors;
- The need for support from the Health Subcommittees of the veterans' affairs committees to hold the Veterans Health Administration (VHA) accountable for adhering to the highest standards of quality care with regard to decisions related to rehabilitation training and the hiring of professionals to provide rehabilitative services to blind and other disabled veterans;
- The need for members of the Veterans' Affairs Committees to support an appropriation of \$840 million for VA research in FY 2020;

We will also provide, at the conclusion of this statement, a list of the legislation BVA is supporting as of March 1, 2019.

I. EXTENSION OF VA BENEFITS TO CAREGIVERS FOR VETERANS OF CONFLICTS PRIOR TO 9/11

While VA provides essential health care services to severely disabled veterans, for many veterans, it is their caregivers who provide the day-to-day services and supports needed to sustain their well-being. Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries. The welfare of caregivers has a direct impact on the quality of care veterans receive, and the quality of life they can sustain. One of the factors that most commonly leads people over age 65 to seek admission to nursing homes is blindness. Such admissions are sought based on a false assumption that nursing homes are the only place where blind persons can obtain the supports and assistance they need. However, there is ample evidence to indicate that paying for nursing home care is neither cost effective for the VA nor in the best interest of most veterans over age 65. Rather, many such veterans can and should age in place, supported by one or more caregivers, and VA support for these caregivers would require a fraction of the cost of nursing home care. BVA concurs with the discussion and recommendations on this issue contained in the Independent Budget for 2019.

Further, we caution members of Congress and VA officials to insure that measures that purport to expand benefits to caregivers for veterans who served in conflicts prior to 9/11 do not inadvertently deny some veterans access to this more cost effective and quality-of-life-enhancing alternative by utilizing eligibility determination tools that result in inaccurate characterization of the catastrophic impact vision loss has on a veteran's life, thereby denying their caregivers much-needed benefits. We urge members of the House and Senate Veterans' Affairs committees to insure that VA's implementing regulations do not define eligibility in a manner that measures need based exclusively on a veteran's ability to perform activities of daily living involving non-sensory physical tasks, such as feeding and grooming oneself. Assessments based on these criteria alone do not provide adequate means to measure the impact of disabilities that are sensory in nature and therefore cannot adequately assess the severity of these disabilities, or the disabled veteran's need for the support of a caregiver. Any VHA policy to expand benefits for caregivers must be implemented in a manner that recognizes that "catastrophic disabilities" substantially impact a range of life activities, including sensory and cognitive functions, and fairly evaluates eligibility based on the severity of disability and a veteran's demonstrated need for caregiver support.

II. REQUEST FOR CONGRESSIONAL OVERSIGHT OF VA COMPLIANCE WITH REHABILITATION ACT EFFECTIVE COMMUNICATION REQUIREMENTS

As the VA implements its much-needed program of modernizing its information technology infrastructure and communication capabilities, two major issues arise that are of particular concern to both VA employees and veterans who have visual impairments that prevent them from reading printed materials. These relate to the limited extent to which the VA's modernization efforts incorporate generally accepted accessibility standards. Sections 508 and 504 of the Rehabilitation Act set forth the obligations of federal agencies to ensure that their programs and services are accessible to both federal employees and members of the public who have disabilities. Although the VA has made significant progress in the area of website

accessibility, as we will describe in detail below, the VA continues to fall short of meeting these obligations in several areas. We believe that greater compliance with these accessibility obligations is both readily achievable by the VA and absolutely imperative. VA is at an important crossroad as efforts to modernize both its IT systems and its communications capabilities ramp up. If accessibility is not properly addressed as part of these modernization efforts, achieving it later will rapidly become both burdensome and cost-prohibitive. In order to forestall such adverse consequences, we urge members of the House and Senate Veterans' Affairs Committees to conduct strong oversight of the VA's policies and practices related to compliance with sections 508 and 504 of the Rehabilitation Act, and that attention be focused on the following issues.

A. VA Communications and Section 504 Compliance

There are more than a million veterans in the U.S. who have diagnosed visual disabilities that impair their ability to read printed material without the aid of magnification. As the number of Americans over age 55 continues to grow during the next 20 years, so will the number of visually impaired veterans. As the VA seeks to enhance its communications with the veterans it serves, the VA must take this demographic shift seriously. We are pleased by the steps that the Department of Veterans Affairs has taken during the past year to put in place policies and practices that will give them the capacity to communicate more effectively with veterans whose disabilities impair their ability to read print. However, given the speed at which communications technologies evolve, and the ever-growing demand for the Department to make more information easily accessible to those it serves, the Department must approach this effort with promptness and agility. VA must move quickly to develop policies and practices that provide the capacity to identify veterans with disabilities that impair their ability to read print, and to document the format(s) in which each veteran is able to read. VA must also develop the capability to produce material in the accessible formats needed by veterans. Failure to address this need now will put the VA at a major disadvantage, both in terms of the extent to which human capital will have to be devoted to it later, and the increased cost that would be associated with retrofitting infrastructure.

It is particularly important that the Veterans Benefits Administration takes steps to increase the effectiveness of their communications with veterans who have disabilities, in relation to claims for benefits. Under current regulations, once VA has been notified that a claimant is visually impaired, VA staff must make three attempts to reach the veteran by phone to notify him or her of any action that has been taken on his or her claim. However, no other accommodations, such as large print, are offered, and will only be provided if the veteran specifically requests them. Further, even notice by telephone is only provided to veterans who have service-connected disabilities, and who have previously received a rating of 70% or higher. Therefore, veterans who have visual impairments rated at less than 70%, whether the underlying disability is service-connected or not, do not qualify to receive even phone calls to alert them of actions taken on their claims, let alone notices of those actions that are sent in a format the veteran can read, such as large print. Additionally, Veteran Service Officers working for the Blinded Veterans Association report that VA regularly fails to make the phone calls required by its regulations. In 2018, our Veteran Service Officers assisted forty-four blind veterans with their appeals of VA's denial of their claims for benefits. In each case, the veterans were asked during the intake process

whether they had received any phone calls from VA notifying them of the decision that was made on their initial claims. Not a single one of these veterans indicated that they had received a phone call. This is a failure rate that is unacceptable.

Even if it was being followed properly by VA, we believe this policy is far too restrictive. VA should, at a minimum, provide notice of actions taken on claims for benefits in the form of a phone call to all veterans who are known by the VA to have significant visual impairments, regardless of whether their disabilities are service-connected or not. Further, we believe that Congress should require the Veterans Benefits Administration to make it easier for veterans who are pursuing claims for increased benefits to request and receive additional accommodations based on their particular needs and disabilities.

Finally, failure to address this issue could have additional consequences, not only for claimants, but for the VA itself. In 2013, the Office of the General Counsel (OGC) advised the VA that by failing to send correspondence to claimants who were known to the VA to be blind in formats they could read, VA was in violation of its statutory obligation to “send proper notice.” The OGC went on to point out that in cases where such improper notice was given, the claim must remain open until such time as the appropriate notice was given. It was noted that this includes claims where decisions have been rendered denying the claim. The OGC stated that in such cases, notice of denial was improperly given, and therefore invalid, thus subjecting the VA to possible litigation for retroactive benefits. As long as the VA fails to serve proper notice in such cases, the amount of any retroactive benefits due to an applicant may continue to compound. It is imperative, for the sake of both the VA and visually impaired veterans involved in the claims process, that processes be put in place whereby VA’s various agencies can:

- Identify those individuals whose disabilities prevent them from reading printed and other textual materials by traditional means.
- Collect information about which alternate formats the VA could use to communicate with these veterans.
- Provide information such as correspondence, memoranda, appointment notices, notices of decisions regarding claims for benefits, and other vital communications to these veterans in accessible formats.

We urge your committees to help us encourage VA to act expeditiously to adopt policies and practices that will enable them to meet these needs sooner, rather than later. To be effective, such policies and practices must be part of the development and implementation of VA’s communications and IT modernization efforts so that measures to address these issues will be incorporated seamlessly into the general communications program. We request that the members of both the House and Senate Veterans’ Affairs Committees utilize your oversight authority to help us hold the VA accountable for making progress toward achieving this goal.

B. VA IT Modernization and Section 508 Compliance

Section 508 of the Rehabilitation Act, which was incorporated into the Workforce Innovation and Opportunity Act of 2015, requires federal agencies to ensure that all electronic and information technologies developed, procured, maintained, or used in the federal environment provide equal access for people with disabilities, whether they are federal employees or members

of the public. A 2012 Department of Justice report indicated that although Section 508 was enacted in 1998, agencies across the federal government continue to fall short when it comes to the implementation and management of compliance with this provision, and the VA is no exception. In spite of this report and several years of ongoing dialogue between the VA's senior IT officers and BVA's national leadership, numerous websites and information technologies utilized by the VA remain out of compliance with the most basic accessibility guidelines. In addition, the VA has repeatedly compounded this problem by introducing new technologies that are not compliant, and in some cases, allowing upgrades that remove accessibility features that were once in place. A case in point is the Veteran Service Officer training course offered by the Veterans Benefits Administration, known as TRIP. Beginning over two years before this course was released, BVA made repeated requests to VA staff asking for assurances that this course would be accessible upon its release, so that blind veterans could take the training and qualify to assist their fellow veterans with their claims. The course was released by VBA in 2018, and the only way it can be accessed is through a website that is incompatible with screen reading software used by blind persons. As is often the case, this state of affairs could have been avoided, if the site's developers had followed industry-standard accessibility guidelines when building the site. Now, barriers to access via screen readers that were inadvertently built into the website's design cannot be readily removed without requiring a major, expensive, overhaul of the entire design.

Even areas associated with Veteran care are directly impacted by inaccessible interfaces. Blinded Veterans face grave concern over the need to share their confidential information with strangers every time they are required to check in for medical appointments by using inaccessible check-in kiosks. For Veterans in the Move program or who use the Health Buddy home-based health and fitness devices, insurmountable barriers prevent them from even being able to navigate the different screens and learn what their basic health status is.

VA still has a long way to go to address even the most basic of barriers currently faced by both VA employees with disabilities, and the veterans served by VA. For this reason, we supported The VA Website Accessibility Act when it was introduced by Rep. Elizabeth Esty in the 115th Congress, and we thank the members of the House for passing this legislation. We are now pleased to support the amended version of this bill, H.R. 1199. We believe that this legislation would encourage this department to finally address its longstanding communications shortfalls before the need to do so grow any greater.

The following 508 compliance issues are areas of specific and ongoing concern:

- Continued reliance on inaccessible kiosks at VA Medical Centers, the use of which is required to check in for scheduled appointments.
- Inaccessible Telehealth tools, namely the Health Buddy home monitoring station.
- VBA web pages containing e-Benefits information that are inaccessible to blind people who use screen readers.
- The continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software in order to do their jobs.
- Inadequate staffing by the VA to ensure its capacity to address internal and external accessibility issues.

- Lack of an enforcement mechanism or other means of addressing compliance issues, so that if equipment, hardware, software, or a website is found to be noncompliant with accessibility standards, someone follows through and addresses the issues that are identified, and thereby fixes the accessibility problem.

We urge you to help us hold VA accountable for progress on these issues. Please stand with us so that blind VA employees will no longer be shut out of significant portions of the VHA and VBA information management systems, and blind veterans will no longer be denied access to VA websites, because of their incompatibility with screen readers and other adaptive equipment used by people with disabilities. Please pass H.R. 1199.

C. Recommendation: Designation of Accessibility Officer within VA

Finally, we suggest that Congress require the VA to create an Information Accessibility Officer position, which would be required in every VISN Network, and each of the four Veterans Benefits Administration (VBA) Regional Centers. These Information Accessibility Officers would serve as liaisons to VA's 508 Compliance Office. They would also be responsible for ensuring that each and every disabled veteran has access to and the necessary knowledge to use VHA and VBA documents and websites. They could also educate veterans on how to navigate VA websites and notify the VA of any barriers that may limit veteran access to information.

III. REQUEST SUPPORT FOR \$20 MILLION APPROPRIATION FOR DOD VISION RESEARCH PROGRAM (VRP) IN FY 2020

BVA, along with other VSOs and MSOs, once again requests your support for a programmatic request for the DOD Vision Research Program (VRP), a Peer Reviewed Medical Research Program (PRMR) for extramural translational battlefield vision research in the amount of \$20 million in FY 2020. BVA appreciated the widespread bipartisan support our request of \$20 million for FY 2019 received from the 115th Congress, and we request that funding be continued at \$20 million in 2020, in order to address identified DOD Gaps in battlefield vision trauma research.

The Peer Reviewed Vision Research Program (VRP) in the CDMRP appropriations funds critical extramural vision research into deployment-related vision trauma that is not currently conducted by any other public or private agency. All other research entities, including VA, the joint DoD/VA Vision Center of Excellence, and the National Eye Institute within the National Institutes of Health, and private foundations combined, allocate less than 1% of their budgets and research resources to vision research. For this reason, the Veteran Service Organizations Independent Budget (VSOIB) supported by twenty-nine other organizations, joins BVA in urging Congress to fund the VRP at \$20 million in FY 2020. See *The Independent Budget Veterans Agenda for the 116th Congress* at: <http://www.independentbudget.org/>

Rationale

One consequence of today's battlefield conditions is that 14.9 percent of those who are evacuated due to wounds resulting from Improvised Explosive Device (IED) blast forces have penetrating eye injuries and TBI-related visual system dysfunction. Upwards of 75 percent of all TBI patients experience short- or long-term visual disorders (double vision, light sensitivity, inability to read print, and other cognitive impairments). With the continued presence of the U.S. in Syria, Iraq, and Afghanistan, coupled with other global threats, such eye injuries will continue to be a challenge. The VHA Office of Public Health has reported that for the period October 2001 through June 30, 2015, the total number of OEF/OIF/OND veterans enrolled in VA with visual conditions was 211,350, including: 21,513 retinal and choroid hemorrhage injuries, 5,293 optic nerve pathway disorders, 12,717 corneal conditions, and 27,880 with traumatic cataracts.¹ The VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications from frequent blast related injuries.

VHA data also reveals rising numbers of the total Post 9/11 veterans with TBI visually impaired ICD-10 Codes enrolled in VHA for vision care in FY 2013 was 39,908, for FY 2015 total 66,968 with symptoms of visual disturbance.² Based on recent estimates from reported TBI Defense Veterans Brain Injury Center (DVBIC) data, the incidence of TBI without eye injury with clinical visual impairment from 2000-2017 is 76.900.³

VHA Blind Rehabilitation Services (BRS) provided data as of August 6, 2018, indicating that 3,439 unique OEF/OIF/OND patients have been seen by Vision Impairment Services Outpatient Rehabilitation (VISOR) programs, and 229 attended Blind Inpatient Rehab Centers.⁴

Research to effectively treat vision trauma and TBI-related visual disorders can have long-term implications for an individual's vision health, productivity, and quality of life for the remainder of military service and into civilian life. John Hopkins Public Health study Oct 2001 to 2nd Q 2017 study using published data estimated that deployment-related eye injuries and blindness have cost the U.S. \$45.5 billion, with \$44.4 billion of that cost reflecting the present value of a lifetime of long-term benefits, lost wages, and family care.⁵

VRP Funding Yields Deliverables

¹ VHA Office of Public Health OIF/OEF/OND Veterans Medical Encounters for Disorders Eye and Vision, FY 2002 to June 30, 2015 Enrollment Code data report.

² VHA Office of Public Health OIF/OEF/OND Veterans Medical Encounters for Disorders Eye and Vision, FY 2002 to June 30, 2015 Enrollment Code data report.

³ 2018 study by the Alliance for Eye and Vision Research—Costs of Military Eye Injuries 2001 to 2017—Published January 26, 2019 in *Military Medicine* journal...

⁴ VHA BRS Data Source: *VSSC OEF/OIF/OND Input & Output Encounters Cube*.

⁵ 2018 Cost of Military Eye Injury and Blindness, study by the Alliance for Eye and Vision Research—accepted for 2019 publication in *Military Medicine* Journal by Johns Hopkins Bloomberg School of Public Health

VRP funds the research into mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBI; and translational research, which facilitates development of critical diagnostics, treatments, and therapies— that can be employed on the battlefield to save vision. Research projects funded by the VRP funding cycles have resulted to-date in 153 published papers that are advancing knowledge about the diagnosis and treatment of blast eye trauma and TBI vision dysfunction. VRP funded-projects have also resulted in 15 patents or applications for patents.

- The development of a portable, hand-held device to analyze the pupil's reaction to light, enabling rapid diagnosis of TBI-related vision dysfunction.
- A new "ocular patch," which consists of nanotechnology-derived reversible glue that seals lacerations and perforations of the eye globe sustained on the battlefield
- A computational model of the human eye globe to investigate injury mechanisms of a primary blast wave from an IED that account for 82 percent of the blast injuries in Iraq and Afghanistan.
- The development of a new vision enhancement system that uses modern mobile computing and wireless technology, coupled with novel computer vision (object recognition programs) and human-computer interfacing strategies, to assist visually impaired veterans undergoing vision rehabilitation to navigate, and interact with people.

Research studies of simulated TBI/blast exposure have yielded information on cell mechanisms of damage to ocular tissues. New therapeutic interventions to prevent the severity of visual system damage resulting from blast overpressure are being explored.

BVA has recently discovered that the CDMRP TBI programmatic leaders at Fort Detrick have decided not to provide \$5 million for TBI vision research grants from their \$120 Million FY 2019 appropriations. For the past five years directors of the TBI program have provided the VRP with \$5 million in funding because the VRP funding level was not sufficient to cover enough grants for non-penetrating TBI vision dysfunction research, and to address additional issues resulting from the growing number of veterans diagnosed with TBI vision disorders. Thus, this vital Vision Research Program once again faces a funding deficit, unless some of the TBI programmatic funding is restored.

IV. REQUEST FOR OVERSIGHT OF VA VISION CENTER OF EXCELLENCE (VCE)

The VA currently provides health care to more than 922,000 veterans who served in Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) and Operation Freedom's Sentinel (OFS).¹ An increasing number of these veterans have vision impairments and hearing impairments, as a result of wounds they received in these wars. Due to the ongoing conflicts around the world today, and the consequent risk that service members will continue to be deployed to dangerous areas, thereby sustaining similar injuries, we can expect this number to continue climbing.

In FY 2008, members of these Committees and the Armed Services Committees from both parties supported the establishment of the Vision Center of Excellence through the FY 2008 National Defense Authorization Act (NDAA, P.L. 110-181). Additionally, the Hearing Center of

Excellence and Limb Extremity Center of Excellence were established by the FY 2009 NDAA (P.L. 110-147). Congressional intent was that the goal of these four deployment injuries Centers of Excellence would be to enhance the care of American military personnel and veterans wounded or otherwise affected by combat eye, hearing, and limb extremity trauma. Care enhancement would come through improvements in prevention, diagnosis, treatment, research, and rehabilitation. These centers are charged with strengthening clinical coordination between DoD and VHA. They were mandated to develop bidirectional joint clinical injury registries with up-to-date information on the diagnosis, surgery, treatment, and follow-up evaluations for the returning injured.

VHA records reveal that 201,980 OIF/OEF/OND veterans with eye conditions entered the VA system for care from October 2001 through March 30, 2015.ⁱⁱ The Hearing Center of Excellence website has 325,000 service members with hearing loss or Tinnitus. Unfortunately, after six plus years of operation, these registries are still not fully bi-directionally functional. While VCE DoD contractors have entered more than 29,000 of the eye-injured into the Defense Veterans Eye Injury Vision Registry (DVEIVR) there have been numerous problems in obtaining VHA's clinical electronic vision health records. While VHA continues to enroll more Post 9/11 veterans with a wide variety of either vision complications from blast-related Traumatic Brain Injuries (TBI) or penetrating eye injuries, the data extraction process has slowed down. BVA is concerned that with the implementation of the new Cerner joint DoD and VHA electronic health record systems, all of these registries will encounter even greater obstacles that hinder their ability to collect vital longitudinal information.

During the past 2 years all four of these COE's were moved into the Defense Health Agency (DHA). BVA also has concerns about the future of VCE staffing and funding levels for FY 2020 through FY 2022. DHA recently announced plans to make significant reductions, across all military services, in the number of personnel from various surgical specialty areas. We are deeply concerned that these reductions will result in fewer forward deployed ophthalmologists in combat zone hospitals, which, in turn, could result in service members with eye injuries not getting the early surgical intervention urgently necessary to "Save Life, Limb, and Eye Sight."

The following information from VHA should highlight the importance of ophthalmologists in both the VA and DoD systems of care:

- In fiscal year 2018, VHA's Office of Specialty Care Services provided Eye Care ([Optometry and Ophthalmology](#)) Services for a record number of 1.81 million veterans at about 381 VA medical facilities located in urban, suburban, rural, and highly rural areas. VA eye care is the third busiest service in VHA, behind primary care and mental health.
- Ophthalmology is the second busiest surgical service, behind general surgery, with over 76,000 cases in FY18.
- The most common surgical procedure performed in VHA is cataract surgery.
- Over 30,000 laser surgery procedures were performed in VA clinics in FY18.
- VA's Ophthalmology workforce consists of over 1200 physicians located at 115 clinics.

BVA would also note a recent GAO report that highlights these same issues.

What GAO Found

Actions Needed to Determine the Required Size and Readiness of Operational Medical and Dental Forces

The Department of Defense (DOD) has not determined the required size and composition of its operational medical and dental personnel who support the wartime mission or submitted a complete report to Congress, as required by the National Defense Authorization Act for Fiscal Year 2017. Leaders from the Office of the Secretary of Defense (OSD) disagreed with the military departments' initial estimates of required personnel that were developed to report to Congress.

Highlights of GAO-19-206,
a report to congressional
committees

V. ADDRESSING ISSUES FACING WOMEN VETERANS

BVA looks forward to working with the VA and members of Congress to improve programs and services for women veterans. It is our hope that some of the concerns that women veterans face, which were highlighted during hearings held by these committees last year will be acted upon in the year ahead. For instance, there is a continuing need for gender-specific healthcare services at VA medical centers across the country. We urge these committees to give the VA the resources it needs to address this need in a timely and comprehensive manner.

Although it is not exclusively a women's issue, military sexual trauma is an issue that commonly affects women servicemembers and veterans. It is also one that has been swept under the rug for too long. We urge members of the Veterans Affairs Committees to continue their vigilant monitoring of VA's handling of Military Sexual Trauma claims to insure that they are handled with sensitivity and fairness, as well as promptness. We also support passage of H.R. 1092, the bipartisan *Service member and Veterans' Empowerment and Support Act*, which expands the definition of Military Sexual Trauma (MST) to ensure service members and veterans who experience online sexual harassment can access VA counseling and benefits. It also codifies a lower burden of proof so more survivors are eligible for trauma and mental health care related to MST, even if they didn't feel comfortable reporting the event to their chain of command while in service.

VI. REQUEST THAT MEMBERS OF THE VETERANS' AFFAIRS COMMITTEES SUPPORT A CHANGE TO SPECIALLY ADAPTED HOUSING GRANT ELIGIBILITY CRITERIA TO INCLUDE BLINDED VETERANS

Under current regulations, in order for a blind veteran to qualify for a grant under the Specially Adapted Housing (SAH) grant program, the veteran must not only have suffered almost total vision loss, but must also lose either the loss of use of a lower extremity, or the extremity itself.

The eligibility standard requires: "Loss of or loss of use of both legs, or Loss of or loss of use of both arms, or Blindness in both eyes having only light perception, plus loss of or loss of use of one leg, or The loss of or loss of use of one lower leg together with residuals of organic disease or injury, or The loss of or loss of use of one leg together with the loss of or loss of use of one arm, or certain severe burns."

Section 202 of Public Law 112-154 also provides that in addition to those Veterans currently eligible for SAH under [38 U.S.C. § 2101\(a\)](#) (see [38 C.F.R. § 3.809](#)), Veterans who served on or after September 11, 2001, and incurred a permanent, but not necessarily total, disability that is "due to the loss or loss of use of one or more lower extremities which so affects the functions of balance or propulsion as to preclude ambulating without the aid of braces, crutches, canes, or a wheelchair" are eligible for the SAH benefit.

In other words, blindness, by itself, is not a significant enough disability to qualify a veteran for a grant under this program that would enable him or her to adapt the home he or she lives in with features that would help to mitigate the vision loss he or she has experienced, and restore some of the independence lost along with his or her vision. We believe this restriction is both unnecessarily harsh and unfair to blinded veterans. Numerous technologies are available that enable a blind person to perform many of the tasks associated with residing in a home by issuing voice commands or listening to spoken menus. Incorporating such technology into a home can make it safer and allow the individual to live more independently. However, these technologies are expensive, and therefore, often beyond the reach of many blind veterans. We believe the time has come to rectify this situation. Therefore, we respectfully request your assistance with changing the eligibility criteria for the SAH program to include Legal Blindness in both eyes, as a disability sufficient to qualify a veteran for a grant under this program.

VII. REQUEST THAT BLINDED VETERANS BE REINSTATED TO ELIGIBILITY FOR USE OF SPECIAL MODE TRANSPORTATION AND GRANTED ACCESS TO LOCAL TRANSPORTATION PROVIDED BY VA

As we reported in our testimony last year, our members continue to be denied access to local transportation that is provided by VHA to veterans with other disabilities. This is especially problematic for veterans who live in rural areas and have either no or very limited options for getting to and from medical appointments. Blinded veterans cannot drive themselves and for many, finding someone to drive them presents a major and frequent barrier to keeping their medical appointments. The Veterans Travel Program (VTP) provides transportation to medical appointments at VA medical centers for veterans with disabilities, but hospitals across the country continue to deny blinded veterans access to this service under the mistaken belief that a reference in the law that created the program to "non-ambulatory" veterans means that eligibility for the program is limited to veterans who use wheelchairs. This situation must be corrected. There are numerous circumstances in which blindness can render an individual unable get from one place to another as a physical disability does. VTP must ensure that blindness is included as a medical justification for VA to authorize the use of Special Mode Transportation so that veterans who are blind can get to local VA medical centers and receive healthcare.

BVA has held many meetings with VHA senior leadership to discuss this issue and we believe that the term "non-ambulatory" should be modified to include any "catastrophically disabled veteran", including those who are blind.

In late October of 2018, VHA informed the BVA that they were close to releasing a new guidance document that would clarify the circumstances under which blind veterans would qualify for use of Special Mode Transportation. However, five months later, we are still awaiting the release. We therefore request that members of the Veterans Affairs Committees contact the Secretary of VA and inquire about when this guidance document will be released.

VIII. FUNDING VHA BLIND REHABILITATION SERVICE (BRS)

Integrated among OIF and OEF veterans with eye injuries, there is a growing number who are aging and experiencing age-related degenerative visual impairments. As of August 6, 2018, 42,583 Veterans were on permanent Visual Impairment Service Team (VIST) Coordinator case management lists. VHA research studies estimate that there are 131,580 legally blinded veterans in the U.S. population. Epidemiological projections indicate that there are another 1.5 million low-vision veterans in the United States with visual acuity of 20/70 or worse.

VA currently operates 13 residential Blind Rehabilitation Centers (BRCs) across the country. These BRCs provide the ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. Unfortunately, the Veterans Integrated Service Networks (VISN) directors and medical center directors at some of the sites where the BRCs are located have failed to replace BRC staff members who retired or transferred to other facilities, claiming that there is no funding to support maintenance of their center's staffing at previous levels. As a result, some BRCs now lack the staffing to help blinded veterans acquire the essential adaptive skills they need to overcome the many social and physical challenges of blindness. Without intervention, we fear that the number of BRCs in this position will grow.

BVA also requests that these Committees provide oversight into how funds allocated to the Blind Rehabilitation Service are actually being used. VHA and the VISN should be required to explain how funds are allocated within and among BRCs. These centers need directed funding to bring staffing levels up to required levels. Directors should not be allowed to divert funds designated by the Veterans Equitable Resource Allocation (VERA) System for these rehabilitation admissions from the blind centers to other general medical operations. BVA is concerned that community care funding contracted under the auspices of the VA MISSION Act will take funds away from these VA rehabilitation centers. There should be no bed closings or hiring freezes on critical blind center staff positions because facilities also need to offer veterans more community care options. We point out that VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of Public Law 104-262.

We call on the Veterans Affairs Committees to conduct oversight to ensure that the VA is meeting capacity requirements within the recognized systems of specialized care, in accordance with P.L. 104-262 and P.L. 114-223. In spite of repeated warnings about these capacity problems, the House and Senate VA Committees have conducted very little meaningful oversight on VA's ability to deliver specialized health care services.

BVA and other endorsers of the VSO Independent Budget for FY 2020 asserted that in order to strengthen the ability of VHA to recruit and retain VHA health care professionals, they must have access to Continuing Medical Education conferences and updates on emerging research and professional development education to meet licensure and certification standards. We continue to believe that access to such educational resources is vital to their ability to appropriately serve our nation's blinded veterans.

Private agencies for the blind lack the necessary full specialized nursing, physical therapy, pain management, audiology and speech pathology, pharmacy, and radiology support services that are available at the BRCs because they are located adjacent to VA hospitals. Also, most private agencies are outpatient centers located in major cities, making access for blinded veterans from rural areas difficult, if not impossible. In many rural states there are no private inpatient blind training centers at all. Therefore, the availability of an adequately-funded and staffed VA BRC is the only option. These veterans should not be forced to utilize these facilities when VHA BRS has the capacity to ensure they have access to a program at a facility that is adequately staffed and funded.

BVA requests that if the VA does contract with private agencies to provide rehabilitation training to blinded veterans, the VA should ensure that the private agencies with which it contracts have a demonstrated capacity to meet the peer reviewed quality outcome measurements that are a standard part of VHA BRS. We further recommend that VA require private agencies with which it contracts to be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Impaired (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, the VA should require those agencies to provide veterans with instructors who are certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

No agency should be used to train newly blinded veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer reviewed vision research.

IX. REQUEST THAT MEMBERS OF THE VETERANS' AFFAIRS COMMITTEES SUPPORT APPROPRIATION OF \$840 MILLION FOR VA RESEARCH IN FY 2020

BVA joins the authors of the Veteran Service Organizations Independent Budget (VSOIB) and the Friends of VA Research Coalition (FOVA) in supporting an appropriation of \$840 million in FY 2020 to fund VA research programs. We believe this level of funding is vital to the sustainability of VA's medical and prosthetics research programs. It would allow for meaningful growth above inflation, and continued investment in groundbreaking programs like the Million Veteran Program (MVP), while also allowing VA to support research on a variety of chronic and newly emerging needs facing our nation's veterans. Additional details on this issue can be found in the Independent Budget: <http://www.independentbudget.org/>

BVA RECOMMENDS:

- That Congress ensures that VA's implementation of benefits for caregivers for catastrophically disabled veterans from previous war eras, is appropriate and timely, and insure that the eligibility criteria employed by VA to determine who is eligible for such benefits do not inadvertently preclude caregivers for blinded veterans from receiving assistance;
- That members of Congress urge VA to develop policies and practices that enable VA's agencies to identify those veterans and VA employees who need access to materials and correspondence in formats other than print by virtue of disabilities, and ensure that they have the capacity to communicate with such individuals in appropriate accessible formats.
- Congress pass H.R. 1199, The VA Accessibility Act as well as conduct an oversight hearing on VA lack of compliance with Section 508 throughout the VHA and VBA Information Technology programs, and require that VA set timelines, funding levels, and staffing goals for addressing areas of noncompliance.
- Members of the Veterans' Affairs Committees express support to Appropriators for funding of the Congressionally Directed Medical Research Program and, Vision Research Program (VRP) at \$20 million in FY 2020.
- Veterans Affairs Committees provide oversight of full establishment of the VCE and the Defense Veterans Eye Injury Registry (DVEIR) on resources, program management, and funding. Request similar oversight for the Hearing Center of Excellence.
- That Congress pass H.R. 1092, the bipartisan bill to improve resources and care for survivors of military sexual trauma (MST), by U.S. Senators Jon Tester (D-Mont.), Lisa Murkowski (R-Alaska) and Congresswoman Chellie Pingree (D-Maine).
- Members of the Veterans' Affairs Committees express support for changing specially adapted housing grant eligibility criteria to enable blinded veterans to qualify based on their legal blindness alone;
- The Veterans' Affairs Committees support reinstatement of eligibility for blinded veterans to use special mode transportation provided by the VA and its contractors, and also request information from the VA Secretary about the status of Special Mode Transportation Policy for visually impaired veterans.
- Veterans Affairs Committees ensure VA's adherence to high standards in the recruitment of employees and contractors who provide rehabilitation training to blinded veterans and urge VA to require certification by recognized accrediting bodies.
- Members of the Veterans' Affairs Committees support in appropriation of \$840 million for VA research in FY 2020.

CONCLUSION

Once again, Chairman Isakson, Chairman Takano, Ranking Member Tester, Ranking Member Roe, and all Members, thank you for the opportunity to present BVA's legislative priorities before you today.

Bills supported by the Blinded Veterans Association as of March 1, 2019.

S. 191

Burn Pits Accountability Act

A bill to direct the Secretary of Defense to include in periodic health assessments, separation history and physical examinations, and other assessments an evaluation of whether a member of the Armed Forces has been exposed to open burn pits or toxic airborne chemicals, and for other purposes.

Sponsor: Sen. Amy Klobuchar (D-MN)

H.R. 663

Burn Pits Accountability Act

To direct the Secretary of Defense to include in periodic health assessments, separation history and physical examinations, and other assessments an evaluation of whether a member of the Armed Forces has been exposed to open burn pits or toxic airborne chemicals, and for other purposes.

Sponsor: Rep. Tulsi Gabbard (D-HI)

H.R. 96

To amend title 38, United States Code, to require the Secretary of Veterans Affairs to furnish dental care in the same manner as any other medical service, and for other purposes.

Sponsor: Rep. Julia Brownley (D-CA)

H. Res. 39

Expressing support for the designation of March 2, 2019, as "Gold Star Families Remembrance Day".

Sponsor: Rep. Bob Latta (R-OH)

H.R. 1092

To amend title 38, United States Code, to expand health care and benefits from the Department of Veterans Affairs for military sexual trauma, and for other purposes.

Sponsor: Rep. Chellie Pingree (D-ME-01)

H.R. 1163

The VA Hiring Enhancement Act

Sponsor: Rep. Vicky Hartzler (D-MO)

H.R. 1199

To direct the Secretary of Veterans Affairs to conduct a study regarding the accessibility of websites of the Department of Veterans Affairs to individuals with disabilities.

Sponsor: Rep. Elaine Luria (D-VA)

H.R. 303

Retired Pay Restoration Act

To amend title 10, United States Code, to permit additional retired members of the Armed Forces who have a service-connected disability to receive both disability compensation from the Department of Veterans Affairs for their disability and either retired pay by reason of their years of military service or combat-related special compensation.

Sponsor: Rep. Gus Bilirakis (R-FL)

S. 208

Retired Pay Restoration Act

A bill to amend title 10, United States Code, to permit certain retired members of the uniformed services who have a service-connected disability to receive both disability compensation from the Department of Veterans Affairs for their disability and either retired pay by reason of their years of military service or Combat-Related Special Compensation, and for other purposes.

Sponsor: Sen. Jon Tester (D-MT).

H.R. 712

VA Medicinal Cannabis Research Act

A bill to direct VA to conduct clinical research with varying forms of medicinal cannabis to evaluate the safety and effects of cannabis on health outcomes of veterans with PTSD and veterans with chronic pain.

S. 629

A bill to require the Secretary of Veterans Affairs to review the processes and requirements of the Department of Veterans Affairs for scheduling appointments for health care and conducting consultations under the laws administered by the Secretary, and for other purposes.

Sponsor: Sen. Jon Tester (D-MT)

S. 606

A bill to improve oversight and evaluation of the mental health and suicide prevention media outreach campaigns of the Department of Veterans Affairs, and for other purposes.

Sponsor: Sen. Richard Blumenthal (D-CT)

BVA also supports the introduction of the following bills:

In the House, **P.F.C Joseph P. Dwver Peer Support Program Act** – to make grants eligible for peer-to-peer mental health groups for veterans on a national scale allowing veterans across the country to benefit from this proven model., and

Supporting Veterans Families in Need Act – to permanently reauthorize supportive services for very low-income families,

Sponsor: Rep. Lee Zeldin (D-NY);

In the Senate:

The Air Carrier Access Amendments Act of 2019.

Sponsor: Sen. Tammy Baldwin (D-WI)

Dr. Thomas Zampieri Biography BVA National President

Dr. Zampieri served active duty as an Army Medic from September 1972 until September 1975. He completed this service at the rank of Sergeant. After graduating from Hahnemann Medical University's Physician Assistant Program in June 1978, he enlisted in July 1978 in the Army National Guard. He retired in 2000 as a Major after 21 years of honorable service. His service included 13 years as a Military Aeromedical Flight Surgeon, logging more than 600 hours of flight operations.

As a civilian, he obtained a Bachelor of Science Degree from the State University of New York and graduated with a Master's Degree in Political Science from University of St. Thomas in Houston, Texas, in 2003. Dr. Zampieri completed his Political Science Ph.D. at Lacrosse University in December 2005. He was employed on April 20, 2005 as the Director of Government Relations for BVA, presenting testimonies before U.S. Congressional Committees on a variety of veterans' issues prior to his retirement on November 22, 2013.

He was appointed in January 2014 to serve on the Association's Board of Directors as District Director of the Texas region, and was elected Vice President of BVA in August 2018. On January 29, 2019 he assumed the office of President of BVA. He is also the chairman of the Government Relations & Legislative Committee for BVA.

Dr. Zampieri has 5 percent vision in both eyes resulting from degenerative retinal disease. He has volunteered since 2010 in planning an award-winning international exchange program with the Blind Veterans UK known as Project Gemini. He has organized briefings with senior defense medical officials concerning military eye injuries, blast traumatic brain injuries with vision dysfunction, defense vision trauma research program, and rehabilitation services with the DOD, VA, and UK officials. He is also a member of the Academy of Political Science.

Endnotes

ⁱ VA FY 2017 Budget Press Release February 10, 2016 War Related Health Care Services.

ⁱⁱ VA Office Public Health, Post Deployment War Injury Related Vision Injury & Illness, ICD-10 OIF/OEF/OND Eye Injury Enrollment Codes FY 2002 – Second Quarter March 31, 2015.

Blinded Veterans Association (BVA) Testimony Summary

- BVA wishes for Congress to ensure that VA's implementation of benefits for caregivers for catastrophically disabled veterans from previous war eras is appropriate and timely, and insure that the eligibility criteria employed by VA to determine who is eligible for such benefits do not inadvertently preclude caregivers for blinded veterans from receiving assistance.
- BVA stresses the need for continued Congressional oversight of VA's compliance with the Rehabilitation Act's (part of the Workforce Innovation and Opportunity Act of 2015) effective communication requirements, particularly Sections 504 and 508. BVA suggests the creation of a VA "Accessibility Officer" to oversee accessibility within VA, and supports passage of H.R. 1199, which would require VA to conduct a study into the accessibility of its websites to individuals with catastrophic disabilities.
- BVA urges an appropriation of \$20 million for the DoD Vision Research Program in FY 2020 in order to strengthen the only research program in the nation that focuses on prevention and treatment of combat-related eye injuries and visual dysfunction.
- BVA requests Congress conduct oversight of the implementation of the Vision Center of Excellence, joint Defense Veterans Eye Injury Vision Registry; as well as the hearing Center of Excellence.
- BVA urges Congress to pass H.R. 1092, the bipartisan bill to improve resources and care for survivors of military sexual trauma (MST), by U.S. Senators Jon Tester (D-Mont.), Lisa Murkowski (R-Alaska) and Congresswoman Chellie Pingree (D-Maine).
- BVA supports changing specially adapted housing grant eligibility criteria to enable blinded veterans to qualify based on their blindness alone.
- BVA urges Congress to support reinstatement of eligibility for blinded veterans to use special mode transportation provided by VA and its contractors.
- BVA urges the Veterans' Affairs Committees to hold the Veterans Health Administration (VHA) accountable for adhering to the highest standards of quality care with regard to decisions related to rehabilitation training and the hiring of professionals to provide rehabilitative services to blind and other disabled veterans.
- BVA requests the Veterans' Affairs Committees to support an appropriation of \$840 million for VA research in FY 2020.



Statement of
Jewish War Veterans of the USA
2019 Legislative Priorities
Before the Joint House and Senate
Veterans Affairs Committees
March 12, 2019

Presented by
Dr. Barry J. Schneider
National Commander, JWW

National Commander Dr. Barry J. Schneider

Barry is a retired Air Force Major with 20 years of active military service. His assignments included: NORAD IG Team; Combat Crew Commander; Instructor Crew Commander and Standardization Evaluator for both Titan II and Minuteman Strategic Missile Weapon Systems; Commander of the 44th Strategic Missile Wing Headquarters Squadron and the Chief Administrative and Logistic Services at the Morocco US Liaison Office United States Embassy in Rabat, Morocco; Commander of the 57th Fighter Interceptor Headquarters Squadron in Keflavik, Iceland and Commander of the 7th Combat Support Group Headquarters Squadron in Texas. He graduated from the Squadron Officers School, Air Command & Staff College, Command Staff Officers course and Defense Institute for Security Assistance Management.



Barry worked for the Fort Worth Independent School District for 16 years serving as a Central Office Administrator in the Human Resources Department and became a Certified Records Manager. He completely revamped the procedure for maintaining and preserving employee records for the FWISD. He served as a board member of the Texas State Library Records and Archives Commission.

In 1994, Barry joined the Jewish War Veterans, Post 755 in Fort Worth, TX and became a Life Member. He is also a life member of National Museum of American Jewish Military History (NMAJMH). He served as Post Commander from 2005-2007 and received the Post Member of the Year Award in 2007. He served as Department Commander for Texas, Arkansas, Oklahoma and Texas (TALO) from 2012-2014 and National Executive Committee member from 2014-2016. He developed and organized two JWW Posts in Oklahoma City, OK and Shreveport, LA in 2013 and a new Ladies Auxiliary in Fort Worth, TX in 2016.

Barry serves/d as Chairman of Vietnam Veterans Committee, Chairman of the Scouting Committee, Vice-Chairman of the Youth Achievement Committee, Convention Committee member, Personnel Committee member, Resolutions Committee member, Awards Committee member, NMAJMH Representative and the JWW Representative at the annual Jewish Warrior Weekend at Texas A&M 2017 and 2018. Barry has been a lifelong Boy Scout. As a youth, he earned the Eagle Scout award and the Ner Tamid Jewish religious emblem. As an adult, he served as Assistant District Commissioner for BSA Transatlantic Council in Turkey and Morocco. He was awarded the Silver Beaver award for sustained exemplary service and the Shofar Jewish religious award for service to Jewish Scouting.

Barry earned a BA in History from California State College in 1967, MEd in Guidance and Counseling from South Dakota State University in 1976, MA in Management from Webster University in 1986 and Ed.D. in Educational Leadership from Nova Southeastern University in 1996.

Barry was born and raised in St. Louis, Missouri. He was married to Dolores (Finkelstein) for 49 years. Dolores passed away in 2015. They have two children, daughter Myla and son Eric, and two grandchildren.

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INTRODUCTION

Chairman Takano, Chairman Isakson, and distinguished Members of the House and Senate Committees on Veterans' Affairs, my fellow veterans and friends, I am Dr. Barry J. Schneider, the National Commander of the Jewish War Veterans of the U.S.A. (JWV). JWV was established in 1896 and was congressionally chartered August 21, 1984.

JWV advocates for all veterans regardless of their religion. We provide counseling and assistance to veterans encountering problems dealing with the Department of Veterans Affairs (VA), and other entities with which our members work.

JWV has been helping veterans and preserving the legacy of American Jewish military service for over 123 years. We represent veterans from all conflicts.

Volunteering at VA facilities, hosting educational programs, supporting patriotic organizations like Scouts of America, and advocating on behalf of all veterans lead the efforts our members make to serve the American veteran and our country.

The following veteran issues are the most relevant and concerning to our members. Last month, we brought these important issues to Capitol Hill, in member-led meetings with individual members of Congress and the Senate. JWV urges the Senate and House Committees to address our concerns for all veterans. JWV strongly supports:

- No privatization of the VA
- VA availability for all veterans
- Suicide prevention
- End veteran homelessness

This past February 13 and 14, our National Executive Committee members were here in Washington to meet with their Senators and Representatives as part of JWV's Capitol Hill Action Days. Our members prepared diligently for these important meetings and successfully presented our priorities to your colleagues, their members of Congress and congressional staff.

Mr. Chairman, on March 15, we at JWV will celebrate our 123rd birthday. For these 123 years, JWV has advocated for a strong national defense and fair recognition and compensation for veterans. The Jewish War Veterans of the USA represents a proud tradition of patriotism and military service to the United States.

NO GOVERNMENT FUNDING

For the record, the Jewish War Veterans of the USA, Inc., does not receive any grants or contracts from the federal government. This is as it should be.

THE MILITARY COALITION (TMC)

JWV continues to be a proud member and active participant of The Military Coalition (TMC). Past National Commander Norman Rosenshein, JWV's National Chairman, serves on the Board of Directors.

JWV requests that the Senate and House Committees on Veterans' Affairs do everything possible to fulfill the legislative priorities of The Military Coalition.

NO PRIVATIZATION OF THE VA

JWV is strongly opposed to the healthcare of veterans being privatized. Privatizing VA healthcare would mean worse healthcare for veterans.

The VA system is designed specifically to meet the needs of veterans. That means amputees, paralyzed veterans, blinded veterans, the traumatic brain injured, blinded veterans, and PTSD sufferers see medical personnel in the VA who specialize in these types of combat related injuries and who have the knowledge to deal with them. Privatizing the VA, i.e., changing the VA and giving every veteran a healthcare card, would result in the loss of access to these invaluable specialists.

The traumatized veteran needs medical personnel who are experienced working with these specific types of problems.

The Jewish War Veterans of the USA asks the members of this joint committee to firmly resist any, and all efforts of those who want to privatize the VA.

AVAILABILITY OF VA ACCEPTANCE TO ALL VETERANS

About ten years ago, there was a VA policy that category 7 and category 8 veterans were not able to receive care in VA medical facilities.

JWV strongly opposes that concept. JWV strongly opposes any concept that closes the door of the VA to any veteran. VA Medical Centers should be available 24-7 to all veterans.

Every veteran should have access to VA medical care through the VA.

REORGANIZATION OF THE DEPARTMENT OF VETERANS AFFAIRS

There currently exists within the Department of Veterans Affairs, the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery Administration. There are numerous agencies and administrations that sponsor, oversee and fund other programs designed to help and assist veterans scattered throughout the Federal bureaucracy.

These various agencies do not necessarily coordinate these programs in a cohesive manner. The Veterans' Education, Transition and Opportunity Prioritization Plan (VET OPP Act of 2018) would place under the VBA economic opportunity programs for veterans and their survivors and families. The VET OPP Act of 2018 would create a new Bureau within the Department of Veterans Affairs entitled the Veterans Economic Opportunity and Transition Administration, led by an Under Secretary appointed by the President with the advice and consent of the Senate.

The new Administration would absorb several programs now within the VBA, including vocational rehabilitation and employment programs, educational assistance programs, housing and loan programs, and verification of small businesses owned by veterans. This organization would also capture the Department of Defense's Transition Assistance Program but would not disturb the employment assistance programs now within the Department of Labor. We join with several of our fellow veterans' organizations and associations in support of the VET OPP Act of 2018. THEREFORE, the Jewish War Veterans of the USA joins with those who support the passage of the Veterans' Education, Transition and Opportunity Act of 2018 (VET OPP Act of 2018).

STAFFING OF VACANT VA POSITIONS

The VA has many staff vacancies in its healthcare facilities. Some estimates are as high as 40,000 medical personnel and staff. These vacancies result in patients not getting appointments in a timely manner, adversely impact on their quality of care, and affect staff morale in a negative way.

JWV asks each of you on this joint committee to provide the necessary funding to recruit and retain the right personnel to fill the medical staff shortages in VA medical facilities.

VA'S OUTDATED COMPUTER SYSTEMS

This past fall, thousands of veterans on the G.I. Bill watched their bank accounts dwindle because of the VA's technology failures.

The problem began this past summer when the VA's benefit processing system buckled under new formulas for G.I. Bill students. As a result, scores of veterans faced long delays in their G.I. Bill payments.

The VA's computer systems do not adequately support VA patients. There are those who say the cause is insufficient funding and those who believe the VA does not have the necessary IT talent.

JWV urgently requests the Veterans Affairs Committees to hold hearings to determine the true cause of the VA's IT failures.

BURN PITS

Burn pits are defined as open-air pits used to burn war chemicals, paint, medical and human waste, metal/aluminum cans, munitions and other unexploded ordnance, petroleum and lubricant products, plastics, rubber, wood, and discarded food. There were 197 burn pits operating in Afghanistan as of 2011 and 63 operating in Iraq as of November 2009, prior to new regulations being enacted for Iraq.

The Department of Defense estimates reveal that between 65,000 and 85,000 pounds of waste were disposed of each day at large bases (large being defined as over 1,000 military), and various peer review studies suggest an association between burn pit proximity and respiratory illness. The Departments of Defense and Veterans Affairs maintain that any ill effects from exposure to burn pits is temporary and will pass once the military member is removed from the area.

The American Public Health Association has developed a series of recommendations including:

1. Working with the Afghan troops to end the use of burn pits and remediate the area surrounding them;
2. Studying, at independent universities and non-governmental organizations, the long-range effects of exposure at burn pits;
3. Requiring the VA to make the current airborne hazard and burn pits registry fully functional;
4. Requiring those now working near burn pits to wear protective gear and enter into long-term medical surveillance;

The Jewish War Veterans of the USA calls upon both the Executive and Legislative branches to immediately implement the recommendation of the American Public Health Association.

SUICIDE PREVENTION

The Department of Veterans' Affairs continues to report some 20 suicides per day. This is unacceptable.

The Jewish War Veterans of the USA acknowledges the efforts taken to reduce and prevent this rate of suicide.

The Jewish War Veterans of the USA calls upon the Department of Veterans' Affairs to increase their efforts in suicide prevention.

EQUAL TREATMENT AND FULL RANGE OF HEALTHCARE SERVICES FOR FEMALE VETERANS

There are unique medical needs for women veterans which continue to be inadequately met by the VA. For instance, according to the U.S. Government Accountability Office (GAO)³, 27 percent of VA medical facilities lacked an onsite gynecologist, while the number of women veterans utilizing the VA medical system has increased by some 80% over the course of the last decade.

In areas where the VA does not provide gender-specific services to women veterans, they must depend on Choice Act providers. While the number of obstetricians and gynecologists under the Choice Act has increased, some areas still lack these providers, according to a Veterans Health Administration (VHA) analysis. Although the VHA monitors access-related Choice performance measures (such as timely appointment scheduling) for all veterans, it does not have such measures for women veterans' gender-specific care, such as mammography, maternity care, or gynecology.

All too often, women cannot obtain information and counseling through the VA on issues of reproductive health care, and an increasing number of women suffer from Military Sexual Trauma and Post Traumatic Stress. There are situations wherein women veterans may be more open and candid speaking to a female medical and mental health provider.

There is now before the Senate, S.2402, which had been passed by the House of Representatives (H.R. 2147). This bill requires the Secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for female veterans. The bill directs the Secretary to seek counselors with expertise in female gender-specific issues and services and employment mentoring. The target population is female veterans who suffer from post-traumatic stress disorder or other mental health conditions, who are homeless or at risk of being homeless, or are at risk of suicide.

The Jewish War Veterans of the USA calls upon the Congress to provide adequate resources to the VA to:

- a. Provide women veterans with comprehensive health care in a timely and geographically accessible manner.
- b. Provide women veterans with reproductive information and counseling, as appropriate.
- c. Hire sufficient gynecologists to have services available to women veterans.
- d. Have available a sufficient number of female medical and mental health trained professionals so as to be able to meet the needs of women veterans who would prefer services provided by a female provider.
- e. Have every woman veteran screened to detect if the veteran suffered Military Sexual Trauma during the course of her service regardless of whether she reveals that assault or harassment and divert her to appropriate services and counseling.

f. Create a long-term plan to address the future needs unique to women veterans in anticipation of a growing percent of women in the military and the increased deployment of women serving in the National Guard and Reserve components.

h. In situations where there are no appropriate services within 40 miles of the nearest VA facility, or an appointment cannot be made within 30 days, allow the veteran to utilize the medical services of a pre-authorized provider.

The Jewish War Veterans of the USA **strongly supports the Deborah Sampson Act S 681** which would improve the benefits and services provided by the VA to women veterans.

g. Make available for women veterans, Women's Clinics at all VA facilities, regardless of size.

ILLNESS CAUSED BY DEFOLIANTS, TOXINS, AND OTHER HAZARDOUS SUBSTANCES

Members of the military were exposed to chemicals and defoliants such as Agent Orange during the Vietnam War. Servicemembers in Afghanistan, Iraq, and southwest Asia, were, continue to be exposed to a cocktail of poisons and other hazardous substances from "burn pits" and other sources.

The long-term effects of these poisons, toxins and other hazardous materials not only causes illness in the veterans but, also may cause birth defects in the offspring of the veterans spanning more than one generation. The true extent of the use and exposure to these toxic chemicals is still unknown as to how they were transported and sprayed in Korea, the Philippines and other locations, both stateside and overseas, sailors aboard the "Blue Water" Navy ships' as well as numerous members of the Marines and Air Force flight crews were exposed by airborne and drinking water contaminants that the Department of Veterans Affairs denies occurred.

The Jewish War Veterans of the USA demands that the Department of Defense and Veterans Affairs acknowledge the true extent of the use of chemical and defoliants and calls upon Congress to provide adequate funding for further research into the effects of these toxins and other hazardous substances on the veterans and their families.

BLUE WATER NAVY VETERANS

During the Vietnam War, approximately twenty million gallons of Agent Orange were sprayed over the Republic of Vietnam, contaminating the lands, rivers, harbors, and territorial seas. Under the Agent Orange Act of 1991, Blue Water Navy Veterans were initially entitled to presumptive service-connected disability status, relieving them of the

burdensome process of producing evidence that directly established service connection for a specific health condition. However, in 2002, the VA reinterpreted the language of the Agent Orange Act of 1991 to apply only to veterans who served in the inland waterways or set foot in the Republic of Vietnam.

A study¹, conducted by the Institute of Medicine shows a plausible pathway for Agent Orange to have entered the South China Sea via dirt and debris from rivers and streams. Additionally, a study² conducted by the University of Queensland found that Australian ships' distillation systems, which were identical to the systems used on U.S. Navy ships during the Vietnam War era, in fact, enriched the toxic dioxin in Agent Orange. This contaminated water was used for cooking, cleaning, showering, laundry, and drinking, exposing U.S. Navy personnel to high levels of the toxic chemical.

Jewish War Veterans of the USA strongly supports the passage of **HR 299**, to provide the same presumptive VA benefits to those personnel who served off the coast of Vietnam as are provided to those who had "boots on the ground" in Vietnam. It is quite clear that those who served in the waters off Vietnam are deserving of VA benefits. Thousands of older veterans who served in the territorial waters of Vietnam are now suffering from higher rates of disease, and other chronic health conditions, which can be attributed to exposure to Agent Orange.

When **HR 299** was to come up for a vote, some members of Congress decided that it should be paid for by reducing the veteran's cost of living adjustments. They wanted to have veterans pay for those veterans who were injured by our government. Fortunately, this outrageous proposal was never voted on.

STUDENT VETERANS

The Jewish War Veterans of the USA request the support of each of you concerning protection of student veterans.

The post -9/11 G.I. Bill provides significant benefits. It provides a positive path for returning veterans to reenter society as productive citizens. We thank you for recognizing the importance of this Bill, and for ensuring that it continues to be funded.

However, since the Post-9/11 GI Bill became law, many predatory for-profit colleges have sprung up, and they view our veterans as nothing more than dollar signs.

¹ Institute of Medicine (US) Committee on Blue Water Navy Vietnam Veterans and Agent Orange Exposure. Washington (DC): [National Academies Press \(US\)](#); 2011.

² Jochen F. Müller, Caroline Gaus, Katie Bundred, Vincent Alberts, Michael R. Moore, and Keith Horsley. *Co-Distillation Of Agent Orange And Other Persistent Organic Pollutants In Evaporative Water Distillation*. dynamicplace.com/Bordelon/contents/en-us/Australian%20Study.pdf

There are many reports of aggressive and deceptive targeting of service members, veterans, and their families by these colleges. Predatory for-profit colleges recruit veterans without providing adequate financial counseling and academic support. Predatory for-profit colleges encourage service members and veterans to take out costly loans rather than encouraging them to apply for Federal student loans first; they engage in misleading recruiting practices on military installations; and fail to disclose meaningful information to enable potential students to determine if the college has a good record of graduating and positioning students for success in the workforce.

Recently, forty-nine state attorneys general sued one of these predatory for-profit colleges, Career Education Corporation, for deceiving prospective students about costs, transferability of credits and potential employment. They were fined \$500 million.

Jewish War Veterans of the USA calls upon the Congress to enact creditable standards for schools accepting federal funds for veteran students, including a designated point of contact for academic and financial advisement (including access to disability counseling), to assist service member and veteran students and their families with the successful completion of their studies and with their job searches, and further to have readily available a list of acceptable, accredited institutions.

POW/MIA

The number of still missing and otherwise unaccounted for servicemembers from the Vietnam War is 1,592. The total accounted for since the end of the Vietnam War in 1975 is 991.

For many years JWV has consistently sought the return of all POW's, the fullest possible accounting for the missing, and repatriation of all recoverable remains. At every National Executive meeting, JWV displays the POW/MIA flag in front of the dais to show our continued support.

JWV is pleased with the recent return of Americans still unaccounted for from the Korean War. However, as of December 2018, over 7000 military personnel who fought in the Korean War are still not accounted for.

JWV asks the Congress to provide the necessary personnel and funding to continue to make every effort to bring closure to the families of the missing.

CONCLUSION

Chairman Takano and Chairman Isakson, our great nation must care for its veterans. Our country must, therefore, pay the costs involved.

JWV believes that veterans' benefits are earned through service and sacrifices in defense of the nation and are not "entitlement" or "social welfare" programs. JWV opposes

deficit-driven political decisions that would lump earned veterans' benefits with unrelated civilian entitlement programs.

We thank you for the opportunity to present our priorities to you today.

**Jewish War Veterans
of the United States of America**

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Veterans Helping Veterans

JWV Testimony Summary

- Strongly opposes privatization of veterans' healthcare.
- Strongly opposes any concept that prevents categories of veterans from receiving care in VA medical facilities.
- Supports H.R. 5644 (115th), *Veterans' Education, Transition, and Opportunity Prioritization Plan Act of 2018* or the *VET OPP Act of 2018*.
- Asks Congress to ensure the necessary funding to recruit and retain the right personnel to fill the medical staff shortages in VA medical facilities.
- Asks Congress to hold hearings to determine the true cause of the VA's IT failures.
- Asks Congress to implement the recommendations of The American Public Health Association concerning burn pits.
- Supports increased efforts in suicide prevention.
- Supports equal treatment and full range of healthcare services for female veterans.
- Demands DoD and VA acknowledge the true extent of the use of chemicals and defoliants and calls upon Congress to provide adequate funding for further research into the effects of these toxins.
- Supports H.R. 299, *Blue Water Navy Vietnam Veterans Act*.
- Asks Congress to enact creditable standards for schools accepting federal funds for veteran students.
- Asks Congress to provide necessary personnel and funding to continue to make every effort to bring closure to the families of the missing.

**THE
MILITARY ORDER OF THE PURPLE HEART
OF THE U.S.A.**



**THE ONLY CONGRESSIONALLY CHARTERED VETERANS ORGANIZATION
EXCLUSIVELY FOR COMBAT-WOUNDED VETERANS**

**STATEMENT OF
DOUGLAS J. GREENLAW
NATIONAL COMMANDER**

**BEFORE A JOINT HEARING OF THE
SENATE AND HOUSE COMMITTEES ON VETERANS' AFFAIRS**

MARCH 12, 2019

MILITARY ORDER OF THE PURPLE HEART

**DOUGLAS J. GREENLAW
NATIONAL COMMANDER**

2019 LEGISLATIVE PRESENTATION

**BEFORE A JOINT HEARING OF THE
SENATE AND HOUSE COMMITTEES ON VETERANS' AFFAIRS**

MARCH 12, 2019

Chairmen Isakson and Takano, Ranking Members Tester and Roe, and Members of the Committees, on behalf of the approximately 45,000 members of the Military Order of the Purple Heart (MOPH), it is my honor and privilege to appear before you to offer our testimony.

As I am sure all of you are aware, MOPH is a unique in that our membership is comprised entirely of veterans who were wounded in combat or by an act of terrorism. Still, our advocacy efforts extend to **ALL** veterans, servicemembers, and their families and survivors.

To that end, MOPH will assist any veteran in filing a claim with the Department of Veterans Affairs (VA). Our network of 87 accredited National Service Officers and staff operate out of 67 offices across the country, in addition to Guam and Puerto Rico. In Fiscal Year 2018, they submitted approximately 10,000 claims to VA, resulting in over \$140 million in VA benefits for veterans and their dependents. All of this assistance is always provided free of charge.

Additionally, MOPH gives back to the community through our Scholarship Program. Each year, MOPH grants scholarships to Purple Heart recipients, their spouses, children and grandchildren. This includes surviving family members of Purple Heart recipients who were killed in action. We also maintain a robust VA Voluntary Services Program, as well as our Purple Heart Truck Program, which allows us to provide brand new fully adapted pickup trucks to severely wounded veterans who require vehicle hand controls.

This is a brief overview of the MOPH National Programs. It does not even begin to describe the many contributions of what we believe to be the backbone of our organization, our MOPH members. Organized into 376 Chapters across the Nation, they are constantly engaged with their local communities, serving as ambassadors to the general public by participating in civic events and championing their own unique local programs.

We would also like to take this opportunity to express our appreciation to both Committees for your continued hard work on behalf of our Nation's veterans during the 115th Congress. The successful passage of multiple pieces of significant legislation to include the *VA MISSION Act*, the *Forever GI Bill*, and the *Veterans Appeals Improvement and Modernization Act*, was a monumental achievement, and for that, we are grateful. We also recognize that much of the

Committees' work in the 116th Congress will focus on oversight, and we look forward to working with you and VA to ensure the effective implementation of these new laws.

Still, there are many issues affecting veterans that Congress must continue to address with new legislation. While MOPH always has been, and will continue to be, the first to stand up for our fellow Purple Heart recipients, our priorities reflect the fact that we are staunch advocates for all veterans and their families. With that, *on behalf of the Order*, I am pleased to present the MOPH legislative agenda for 2019.

VA MISSION Act Implementation

The VA *MISSION Act*, which became law last year, contained multiple reforms to VA health care. Most significantly, it established a permanent Veterans Community Care Program (VCCP), replacing previous authorities including the Veterans Choice Program. At the same time, it strengthened internal VA health care by providing resources to recruit and retain more VA doctors. It also required a review of VA infrastructure, and finally expanded the Comprehensive Caregiver Support Program to veterans of all eras. As the product of several different legislative proposals, the VA *MISSION Act* represented a compromise that was ultimately supported by Congress, VA, and the Veteran Service Organization (VSO) community, to include MOPH.

MOPH strongly believes that VA has an obligation to provide high quality medical care to every enrolled veteran. In cases where VA facilities cannot provide veterans with care that is both timely and geographically accessible, veterans must be given the option to receive care from community providers. Still, we believe that VA should remain the primary provider and coordinator of care, and that community care must not come at the expense of funding for VA capacity. Doing so would jeopardize the VA care that many veterans prefer, and MOPH could never support that.

As part of the *MISSION Act*, VA was required to develop access standards for the VCCP, which were recently published for public comment. Among those are wait time and distance standards, which would establish a 20 day wait time standard and 30 minute average drive time standard for primary care, mental health care, and non-institutional extended care services, and a 28 day wait time standard and 60 minute average drive time standard for specialty care. If adopted, these standards are expected to increase both eligibility and cost for community care as compared to the "30 day-40 mile rule" of the Veterans Choice Program. At the same time, VA will require additional resources to implement the new hiring authority provisions of the *MISSION Act*. For this reason, it will be absolutely critical that Congress is prepared to fully fund community care and direct care simultaneously, no matter the cost. While we understand that this will be challenging, MOPH is committed to working with Congress, VA, and our VSO partners to ensure the correct balance is achieved.

Recommended Action: MOPH urges Congress to conduct robust oversight to ensure implementation of the VA MISSION Act strengthens both VA direct care and community care.

Mental Health and Suicide Prevention

Mental health care is certainly one of the foundational services offered at VA facilities. Veterans' mental health conditions often stem from their unique military experiences, both at home and while deployed. VA providers are familiar with the veteran experience, drawing on cultural competencies that cannot be replicated in the private sector.

However, VA continues to struggle to recruit, train and retain enough mental health providers to properly staff its facilities. A recent report by the VA Office of Inspector General found psychiatrists and psychologists to be two of the top five most frequently facility-designated occupational shortages. It is clear that in order to meet veterans' demand for services, Congress must continue to provide VA with the resources it needs to ensure its mental health occupations are fully staffed.

It is well documented that an average of 20 veterans tragically die by suicide each day. Of those, approximately 14 were not receiving VA health care services at the time. Recognizing that one veteran suicide is too many, VA must continue to its community outreach efforts focused on providing every at-risk veteran with the care they need.

VA must also maintain a strong partnership with the Department of Defense (DOD) to ensure at-risk veterans get the care they need. The most recent data reflects that veteran suicide rates are highest among those who served most recently, age 18-29. DOD is aware of which servicemembers are receiving mental health treatment at the time of discharge. In every instance, this information should be shared with VA to ensure recently separated veterans who may be at-risk for suicide get the care they need.

Recommended Action: MOPH urges Congress to provide VA with the resources to fully staff its mental health occupations, and to ensure that DOD shares information with VA about separating servicemembers who may be at-risk for suicide.

Improving Services for Women Veterans

According to VA, the woman veteran population is expected to increase by approximately 18,000 per year over the next 10 years. Women are also increasingly engaged in combat roles on today's modern battlefield. Approximately 1,450 women are current MOPH members, and we firmly believe that VA must continue to improve access to the health care and gender-specific services that they and all woman veterans need and deserve.

For this reason, MOPH strongly supports S. 514, the *Deborah Sampson Act*, introduced by Senator Tester. This comprehensive bill contains many important provisions, to include expanding peer-to-peer counseling for women veterans, extending the period of eligibility for newborn care, retrofitting VA facilities to offer more privacy to women veterans, and increasing the number of gender-specific providers at VA, among other improvements. For far too long, women veterans have had to deal with the reality VA services were not always designed with their specific needs in mind. If VA is to be a truly modern health care organization, it must be

able to provide the full range of care to all those who earned it, and we believe that the improvements made by the *Deborah Sampson Act* are long overdue.

Additionally, one of the biggest barriers to health care for veterans with young children is lack of access to adequate child care. This disproportionately affects women veterans, who are most often their children's primary caregivers. Under no circumstances should any veteran be forced to make the difficult choice to forego care for their own service-related conditions because their children have nowhere to go during their appointments. VA has been operating a successful pilot program to provide child care for veterans, but the pilot sites are limited. Representative Brownley's bill, H.R. 840, the *Veterans' Access to Child Care Act*, would solve this problem by expanding child care benefits to all VA facilities. The House has already passed this legislation, and we urge the Senate to pass it without delay.

Recommended Action: MOPH urges Congress to pass S. 514, the Deborah Sampson Act and the Senate to pass H.R. 840, the Veterans' Access to Child Care Act.

Burn Pit Accountability

It is well known that the U.S. military used open air burn pits as a common practice to dispose of waste at forward operating bases in Iraq and Afghanistan. Burned waste often included things like chemicals, batteries, munitions, tires, human waste, and garbage. As a result, millions of servicemembers were potentially exposed to toxic fumes on a constant basis while deployed to those theaters, and many continue to report unexplained illnesses and symptoms that may be the direct result of that exposure.

In response, VA operates its Airborne Hazards and Open Burn Pit Registry, which is used to collect data from veterans who may have been exposed, help them schedule health exams, and inform them of any future developments on the issue. Currently, registration is done on an opt-in basis. Over 140,000 veterans have chosen to participate in the registry, however, this is only a small percentage of those likely exposed, given that nearly 3 million have served in Iraq and Afghanistan since 2001. MOPH believes that the responsibility for burn pit registration should not fall solely on the veteran, and that DOD and VA should share greater accountability in ensuring that every exposed veteran gets care and benefits they deserve.

For this reason, MOPH supports H.R. 663, the *Burn Pits Accountability Act*, sponsored by Representative Gabbard, and S. 191 sponsored by Senator Klobuchar. This legislation would require DOD to conduct routine medical exams on servicemembers for burn pit exposure, and report those who suffered exposure for enrollment in the Burn Pit Registry.

Additionally, MOPH is pleased that VA has contracted with the National Academy of Medicine to provide a comprehensive review of the respiratory health effects of burn pit exposure. However, the results of the study are not expected to be complete until 2020. Currently, combat veterans discharged on or after January 28, 2003 are eligible for only five years of VA health care enrollment, absent any other enrollment eligibilities. MOPH believes that VA should continue to treat veterans who are suffering from illnesses that may be associated with burn pit exposure beyond that five year window, and we would support legislation to extend

their enrollment eligibility period until the long term effects of burn pit exposure are fully understood.

Recommended Action: MOPH urges Congress to pass H.R. 663 and S. 191, the Burn Pits Accountability Act, and to enact legislation to extend the five year VA enrollment eligibility period for veterans who may have suffered burn pit exposure.

Home Loan Fee Waiver for Active Duty Purple Heart Recipients

The VA Home Loan Program is a valuable benefit that allows veterans to purchase homes with no down payment or mortgage insurance. Instead, a funding fee is used to cover any losses VA may incur in guaranteeing the loans. The fees for first time users are between 2.15 and 2.4 percent of the loan amount, and may be paid upfront or financed as part of the loan, generally adding thousands of dollars to the final amount of the loan. However, disabled veterans and surviving spouses of veterans who died of service connected disabilities are eligible to have the funding fee waived as a benefit of their service.

Combat wounded veterans still serving on active duty, however, are required to pay the funding fee in all cases. MOPH strongly believes that these veterans, the vast majority of whom will almost certainly be eligible for some level of service connected disability rating upon separation, should be entitled to the funding fee waiver on the same basis as disabled veterans who have already been discharged. Many active duty Purple Heart recipients were severely wounded in Iraq and Afghanistan, and spent many months recovering in military hospitals before they were able to return to duty. Others may spend months or years in military hospitals before ultimately receiving medical discharges, but may wish to purchase homes during that period of recovery. MOPH sees absolutely no reason why they should be penalized by the VA Home Loan Program in any way, simply because they continue to serve on active duty in some capacity.

The *Blue Water Navy Vietnam Veterans Act*, introduced by Representative Takano as H.R. 299 and Representative Roe as H.R. 203, would correct this injustice by extending the VA home loan funding fee waiver to active duty Purple Heart recipients. MOPH strongly supports this legislation.

Recommended Action: MOPH urges Congress to pass H.R. 299/203, the Blue Water Navy Vietnam Veterans Act.

Concurrent Receipt

As your Committees are well aware, military retirees who have a service connected disability, rated less than 50 percent, are still subject to an offset of their retired pay by an amount equal to their VA disability compensation. Veterans who were retired from service after less than 20 years due to a disability are subject to the offset, regardless of their disability ratings. While MOPH is grateful for the provision of the 2003 National Defense Authorization Act that provided concurrent receipt of these two benefits for military retirees with disabilities rated at

50 percent or higher and more than 20 years of service, we strongly believe that the time to extend full concurrent receipt to all military retirees is long overdue.

To MOPH, the fact that so many veterans are still subjected to the offset implies that they would somehow be “double dipping” if they were allowed to collect both benefits. We strongly disagree with this. Military retired pay and service connected disability compensation are two different benefits granted for entirely different reasons. Retired pay is granted for having served a full military career as funded by DOD appropriations, while disability compensation is a benefit available to all veterans who were disabled while in service paid, for by VA mandatory funding. We see absolutely no rationale why any military retiree continues to be penalized for suffering a service-related disability by having his or her retired pay reduced.

To correct this injustice once and for all, we urge your support of S. 208, introduced by Senator Tester and H.R. 303, introduced by Representative Bilirakis, the *Retired Pay Restoration Act*, which would extend full concurrent receipt to all military retirees with at least 20 years of service. We also ask that you support Representative Bishop’s bill, H.R. 333, the *Disabled Veterans Tax Termination Act*, which would also extend full concurrent receipt to all veterans who were retired due to a disability.

Recommended Action: MOPH urges Congress to pass S. 208, H.R. 303, and H.R. 333.

SBP/DIC Offset

It is not just veterans who are subject to unjust offsets. Surviving spouses who are eligible for both the DOD Survivor Benefit Plan (SBP) and VA Dependency and Indemnity Compensation (DIC) also experience a dollar-for-dollar offset of their SBP payments. Among surviving spouses, this unfair policy is commonly referred to as the “Widow’s Tax.” Similar to concurrent receipt, the collection of both SBP and DIC should in no way be considered “double dipping,” as they are likewise granted for completely different reasons.

Under the SBP program, retirees make voluntary contributions of 6.5 percent of their retired pay, with the understanding that their dependents will continue to receive 55 percent of their retired pay when they die. This insurance program is completely voluntary, and is a personal decision by each retiree to sacrifice a portion of the payments they receive over their lifetime in order to provide some financial stability to their survivors. In this way, it is similar to the decision to purchase a life insurance policy.

DIC is a VA benefit granted to surviving spouses of veterans who die due to a service-connected disability. This serves as compensation to a spouse when a veteran’s life is cut short due to their service. MOPH sees absolutely no reason why an annuity that was bought and paid for by a veteran should be reduced, simply because they suffered the misfortune of dying of a service-related disability.

While we recognize that the Special Survivor Indemnity Allowance has provided some relief on an incremental, temporary basis, we believe that Congress must act to correct this situation permanently. For this reason, we ask for your support of H.R. 553, the *Military Surviving*

Spouses Equity Act, introduced by Representative Joe Wilson, which would eliminate the SBP/DIC offset.

Recommended Action: MOPH urges Congress to pass H.R. 553, the Military Surviving Spouses Equity Act.

Protecting the Purple Heart Medal

For servicemembers who paid the ultimate sacrifice, the Purple Heart is often the last tangible item their family receives in their memory. In cases where Purple Hearts are lost or stolen, we believe every effort should be made to return those medals to their rightful owners.

Unfortunately, it has come to our attention that certain military memorabilia dealers are selling military-issued Purple Hearts on the secondary market at exorbitant prices, making it harder to reunite veterans and families with lost or stolen medals. Due to the morbid curiosity of some collectors, medals engraved with the names of those killed in action command the highest prices.

The *Private Corrado Piccoli Purple Heart Preservation Act* would put an end to this objectionable practice by making it illegal to sell military-issued Purple Hearts. This would prevent merchants and collectors from profiteering from the sale of those medals, eliminating the market and making it easier to return them to their rightful owners. This bill would not prevent the sale of replacement or duplicate medals through authorized sellers.

This legislation has been introduced by Senator David Perdue as S. 122, and passed the Senate by Unanimous Consent in the 115th Congress. However, the House took no action on it or its counterpart, introduced by Representative Paul Cook. MOPH strongly urges Congress to pass the *Private Corrado Piccoli Purple Heart Preservation Act* without delay.

Recommended Action: MOPH urges the Congress to pass S. 122, the Private Corrado Piccoli Purple Heart Preservation Act.

Chairmen Isakson and Takano, Ranking Members Tester and Roe, this concludes my statement. ***On behalf of the Order***, I thank you for the opportunity to testify today, and I look forward to any questions you or the other Members of the Committee may have.

Yours in Patriotism,



Douglas J. Greenlaw
National Commander

Disclosure of Federal Grants and Contracts:

The Military Order of the Purple Heart (MILITARY ORDER OF THE PURPLE HEART) does not currently receive, nor has MILITARY ORDER OF THE PURPLE HEART ever received any federal money for grants or contracts other than the routine allocation of office space and associated resources at government facilities for outreach and direct veteran assistance services through its Department of Veterans Affairs accredited National Service Officer Program.



Douglas J. Greenlaw



National Commander

Doug Greenlaw is an experienced senior media industry executive with a record of accomplishment in CEO, COO and senior executive positions at such leading corporations as Viacom's MTV Networks, Multimedia, Whittle Communications, The Family Channel, and Switchboard.

Greenlaw has lead three (3) IPOs as CEO and participated as a Board of Directors member on all three. He has lead three public corporations. Greenlaw is currently on the Board of Directors of Alcentra Capital Corporation/Bank of New York/Mellon. Greenlaw is a decorated US Army Veteran having served in Vietnam as a Platoon Leader and Company Commander with the 196th Light Infantry Brigade, a recipient of the Silver Star, 2 Bronze Stars and 2 Purple Hearts.

Doug Greenlaw was elected MOPH National Commander in August, 2018, having previously served as a Founder and Commander of a successful Chapter and a term as State Commander of South Carolina.

MOPH Testimony Summary

- Encourages Congress to conduct oversight to ensure implementation of the *VA Mission Act* strengthens VA direct care and community care.
- Encourages Congress to ensure DOD shares information with VA regarding separating service members who are at-risk suicide.
- Urge Congress to pass *S. 514, the Deborah Sampson Act* and for Senate to pass *H.R. 840, the Veterans' Access to Child Care Act*.
- Urge Congress to pass *H.R. 663 and S. 191, the Burn Pits Accountability Act*, and enact legislation to extend VA enrollment eligibility period for veterans who suffered from *Burn Pit Exposure*.
- Urge Congress to pass *H.R. 299 and H.R. 203, the Blue Water Navy Vietnam Veterans Act*.
- Urge Congress to pass *S. 208 and H.R. 303, Retired Pay Restoration Act*, and *H.R. 333, Disabled Veterans Tax Termination Act*.
- Urge Congress to pass *H.R. 553, the Military Surviving Spouses Equity Act*.
- Urge Congress to pass *S. 122, the Private Corrado Piccoli Purple Heart Preservation Act*.



STATEMENT

Of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

LEGISLATIVE PRIORITIES

For

VETERANS' HEALTH CARE and BENEFITS

116th Congress

Before the

SENATE and HOUSE VETERANS' AFFAIRS COMMITTEES

March 12, 2019

Presented by

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EXECUTIVE SUMMARY

Since the dark days in 2014 when media headlines reported secret waiting lists at the Department of Veterans Affairs (VA) hospital in Phoenix, Ariz., the department has set about closing this chapter in history and steering a new course to rebuild its reputation and commitment to serving veterans.

In the last five years, VA has been undergoing some of the most transformational changes in history in an effort to move its health and benefit systems into the 21st century. Congress has played a crucial role in helping VA move out of its antiquated and bureaucratic ways of doing business in order to put the nation's nearly 22 million veterans at the center of all its reform efforts.

This began with the swift passage of two key pieces of legislation: the Veterans Access, Choice and Accountability Act of 2014¹ and Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015², as well as additional funding to address shortfalls in several VA Health Administration (VHA) accounts; these bills provided the foundational steps needed to begin reforming VA's health care and benefit systems.

In more recent years, the monumental passage of a number of other massive legislative reform bills has propelled the department on a path to achieving the much-needed overhaul veterans deserve. This includes such legislation as:

- ***The Veterans Affairs Accountability and Whistleblower Protection Act***, establishing an Accountability and Whistleblower Protection Office in VA to advise the secretary on all matters relating to employee accountability and senior executive service and supervisory misconduct, and revising whistleblower protections, signed into law June 23, 2017.³
- ***The Harry W. Colmery Veterans Educational Assistance Act***, improving veterans' G.I. bill education benefits, signed into law August 16, 2017.⁴
- ***The Veterans Appeals Improvement and Modernization Act***, modernizing the woefully outdated benefits claims appeals process at the VA, signed into law August 23, 2017.⁵
- ***The John S. McCain III, Daniel K. Akaka and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act***, streamlining and strengthening VA community care and other medical program enhancements to ensure veterans receive efficient, timely, and quality care, signed into law June 6, 2018.⁶

In addition to legislative overhauls, in June 2017, then-Secretary Dr. David Shulkin announced VA would adopt "the same EHR [electronic health record] system as the Department of Defense

¹ P.L. 113-146, or the Choice Act

² P.L. 114-41, or the VA Budget and Choice Improvement Act

³ P.L. 115-41

⁴ P.L. 115-48, or the "Forever GI Bill"

⁵ P.L. 115-55

⁶ P.L. 115-182

(DoD), now known as MHS [military health system] GENESIS.”⁷ The Cerner contract, according to VA, will “ultimately result in all patient data residing in one common system and enable seamless care between the Departments without the manual and electronic exchange and reconciliation of data between two separate systems.”

Since then, Congress has put forth other legislative requirements and appropriations to assure VA and DoD achieve full interoperability in transferring medical data between their respective departments, including data transfer with academic affiliates and community partners — something never done before, but which MOAA, other VSO stakeholders, and Congress have been pressing to achieve for over two decades now.

These reforms, while necessary and innovative, significantly challenge the status quo and will likely bring to the forefront a number of other underlying systemic issues plaguing the department, reported by the Government Accountability Office (GAO) for years in its high-risk areas series on federal agencies. In its most recent report⁸, GAO highlighted several areas in VA health care needing substantive attention:

“Since we added VA health care to our High-Risk List in 2015, VA has acknowledged the significant scope of the work that lies ahead in each of the five areas of concern: (1) ambiguous policies and inconsistent processes; (2) inadequate oversight and accountability; (3) information technology (IT); (4) inadequate training for VA staff; and (5) unclear resource needs and allocation priorities. It is imperative that VA maintain strong leadership support, and as the new administration sets its priorities, VA will need to integrate those priorities with its high-risk actions...”

VA developed an action plan for addressing its high-risk designation but the plan describes many planned outcomes with overly ambitious deadlines for completion. We are concerned about the lack of root cause analyses for most areas of concern, and the lack of clear metrics and needed resources...In addition, with the increased use of community care programs, it is imperative that VA’s action plan discuss the role of community care in decisions related to policies, oversight, IT, training, and resource needs.”

While GAO specifically addresses high-risk areas within VHA, policy, oversight, IT, training, and resource needs are issues prevalent across the agency in all administrations and not isolated to its health system, which is integrally and critically aligned with other operational systems within the VA Benefits Administration (VBA) and National Cemetery Administration (NCA).

⁷ <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2914>

⁸ GAO-17-317 HIGH RISK SERIES: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others

While MOAA has a number of legislative priorities for 2019, the association recognizes there is no higher priority for veterans than to ensure Secretary Robert Wilkie and his staff have the opportunity, tools, and support they need to implement these critical reforms. In order for the department to be successful, Congress, VA, the administration, and military and veterans service organizations must ensure there is ongoing monitoring, oversight hearings, and — most important — transparency, as well as continuous funding and resources to make VA a viable and sustainable institution veterans and their families can count on today and for decades to come.

CHAIRMEN ISAKSON AND TAKANO AND RANKING MEMBERS TESTER AND ROE, on behalf of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA's major legislative priorities for veterans' health care and benefits for 2019.

MOAA does not receive any grants or contracts from the federal government.

The association believes the 115th Congress was one of the most successful for veterans in recent years, due to the committees' unwavering commitment to working in a bipartisan and bicameral way on behalf of our veterans and uniformed servicemembers and their families while other congressional committees struggled to do their work. MOAA commends you for the monumental reforms and measures enacted to change the trajectory of VA in the next 20 years, improving the health and benefits systems that are important to those serving our nation.

MOAA joins our veterans service organization (VSO) partners in thanking Congress, the administration, and VA for including our organizations in the policy-making process and enacting these consequential measures.

MOAA recognizes the current fiscal challenges and constraints facing the 116th Congress. Our organization remains committed to working with lawmakers to find solutions during these challenging times.

As one of the cochairs of The Military Coalition (TMC, 32 military and veterans service organization partners representing 5.5 million members), our work in supporting veterans is guided by three principles in executing our advocacy mission:

- promoting national recognition and understanding of military service and how health care and benefits are earned through service and sacrifice in defense of the nation and are qualitatively different from those normally described as "entitlement" or "social welfare" programs.
- opposing deficit-driven or political decisions that would erode foundational services and benefits delivered through the VHA, VBA, and NCA or decisions that would align veterans' earned medical or other benefits with unrelated federal or civilian benefit programs.
- opposing proposals that would eliminate or diminish veterans' health care and benefits to overcome national or federal agency economic woes.

MOAA and TMC are confident that if we continue to work together in the same fashion as with the previous Congress, veterans will receive the level of health care and benefits they have earned and deserve. We are not, however, opposed to responsible reform efforts that will yield greater efficiencies within VA, reduce wasteful spending and practices, and allow for the fulfillment of promises made to our veterans. While we recognize the fiscal pressures the committees are under, MOAA considers it our sacred obligation as a leadership organization to do what's right for

veterans and their families and to do all we can to make them as whole as possible as they live out their lives once taking off the uniform.

This year MOAA will focus our advocacy efforts not only on assuring the implementation of major reforms mentioned earlier, but also on ensuring any legislation enacted in this Congress results in the safeguarding and improvement of timely access to service-earned VA benefits.

VETERANS' HEALTH CARE PRIORITIES

HEALTH CARE SYSTEM MODERNIZATION

Passage of the VA MISSION Act June 6, 2018, was the culmination of almost four years of continuous negotiation and unrelenting pursuit to fix VA's Choice program and reform the veterans' health system. Its enactment in law was a victory for veterans.

The legislation is historic for a number of reasons, the least of which is because it became a law in just a few short weeks. It also represents a major shift in how the VA will deliver care — a system virtually untouched by major transformation in more than 25 years. In the end, these reforms are expected to cost in excess of \$50 billion over the next five years. That estimate could skyrocket if system improvements aren't carefully managed, with ongoing oversight during implementation.

Congress, the administration, and the VA deserve a great deal of credit for this historic move and for keeping VA health care reform a priority. In the end, thanks to the commitment and shared desire to make veterans' health care better, congressional leaders, administration officials, and veterans groups remained intent on keeping the dialog open and inclusive throughout the process, which ultimately clinched the victory.

Now the hard work begins, as VHA moves out on these reforms and begins integrating its community care programs — work which will require a great deal of vigilance and oversight in order for the department to strike the right balance of public and private care, while at the same time ensuring it maintains the ability to be the primary resource for delivering veterans' health care.

Nine months into implementation, VA just last month released its proposed rules for accessing the VA Community Care Program (VCCP) and urgent care with private retail providers, leaving a very short three months to meet the congressional deadline for implementation of June 6, 2019.

MOAA, like many members of Congress and other VSO stakeholder groups, was very disappointed not to have input into the rule-making, as had been expected. It is our hope that, going forward, VA will be more transparent and inclusive as it rolls out the MISSION Act. Given the massive number of provisions in the law, VA will need the help of all stakeholders to keep the

reform process moving in the right direction if veterans and their families are ever to realize the fruits of the hard work put forth on their behalf.

MOAA will continue to monitor and actively engage in the implementation of the VA MISSION Act by:

- refining the measure as necessary to ensure the following four main pillars of the Act are implemented as intended by Congress:
 1. Consolidating VA's community care programs
 2. Expanding the VA Program of Comprehensive Assistance for Family Caregivers (PCAFC) to eligible veterans of all eras
 3. Providing VA the necessary flexibility to align its infrastructure footprint with the needs of our nation's veterans
 4. Strengthening VA's ability to recruit and retain quality health care professionals
- expanding the VA Program of Comprehensive Assistance for Family Caregivers outlined in the Act to include "illness" as a condition for defining serious injury for purposes of program eligibility.

No veteran should be left with the impression VA isn't responsible for providing them the health care they require. Accordingly, MOAA is supportive of legislative solutions and funding scenarios that preserve foundational and specialty services inherently under the purview of VA, place VA as the primary provider of medical care and services, and provide for clinically appropriate solutions and patient outcomes across the system, leaving no veteran behind. As such, VA must have the necessary funding to implement the reform legislation, including a budget to sustain the integrated health care network over the longer term, both direct care and community care (or non-VA care).

Concurrently, the association will continue to monitor funding for Choice-VCCP and address any funding disparities as necessary. We urge the committees to invest in the modernization of VHA technology, financial, infrastructure, electronic health record, and human resource systems. It is imperative VA has the necessary resources, funding, and staffing if it is to deliver timely access to high-quality health care. Equally important is the need to preserve and enhance VA's core health system mission functions — clinical, education, research, and national emergency response.

MOAA continues to be an avid champion of our VSO partners (Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars), coauthors of *The Independent Budget (IB): Veterans Agenda for the 116th Congress*⁹. Once again, we ask the committees to consider the IB's recommendations when determining VA's budget to ensure VA has adequate funding for delivering timely, quality health care when and where veterans need it.

⁹ <http://www.independentbudget.org>

MOAA asks the committees to:

- *reject proposals aimed at cutting or eroding VA foundational health care services or modernization efforts, as well as efforts to use veterans' disability compensation or other benefits to pay for VA health care requirements.*
- *provide a continuous, full level of funding for VHA, aligning funding, staffing, and resources to meet veteran needs, which includes preserving foundational programs and services unique to VA to meet evolving veteran and health system requirements.*
- *provide continuous congressional monitoring, oversight, and accountability for all VHA reforms and organizational changes.*

VHA HEALTH CARE WORKFORCE

While VA touts turnover in its health system “compares favorably with the healthcare industry, including for those occupations identified as mission critical,”¹⁰ MOAA remains concerned VHA vacancy rates will continue climbing well beyond the more than 42,000 already reported,¹¹ especially with the advent of the MISSION Act and other significant health system reforms — multiple competing priorities which have the potential to further limit the department’s capacity to provide care.

MOAA applauds Secretary Wilkie’s efforts in recent months to look at more robust and aggressive initiatives to attract and retain high-quality providers. These efforts and momentum must continue if the department is to compete for professionals in health care markets across the country in order to fill these vacancies and prevent any erosion in VHA’s reputation as “providing veterans the same or better care at VA as patients at non-VA hospitals.”¹²

¹⁰ News Release, August 31, 2018: VA releases data on vacancies as required under MISSION Act, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5104>

¹¹ VA MISSION Act Section 505 Workforce Data, February 2, 2019, <https://www.data.va.gov/dataset/va-mission-act-section-505-data>

¹² Journal of General Internal Medicine, October 2018, Volume 33, Issue 10, Pp 1631-1638: Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings, <https://link.springer.com/article/10.1007%2Fs11606-018-4433-7>

One MOAA veteran shared her concerns on this topic and experiences at her VA medical facility:

Interestingly I have been using the VA since 1995 and have had great success with their care until recently. I am in category 1. In the past two years I have been assigned five different medical providers because the VA cannot keep them. They all keep leaving. I am a cancer survivor who is not considered cured. I have had three different tests to keep everything in check. None of these tests have been reviewed with me.

I used to get a written summary of these in the mail but for the first time since I have been using the VA this has not happened. I called the VA and did get an appointment but not with the doctor I was told I was last assigned to. I have a different medical provider again and was not notified of this change. Without the VA directly saying it I was definitely dropped through the cracks and they started scrambling to rectify this situation but only after I called it to their attention.

Is the new VA legislation proving to be a real improvement? I am very concerned.
Maj USAF Retired, Helena, Mont.

Specifically, MOAA urges Congress to eliminate employee vacancies by:

- *recruiting and retaining health care professionals, especially in high-shortage areas such as physicians, physician assistants, mental health care providers, and nurses from other government and civilian sectors*
- *implementing independent practice authority for advance practice nurses (APRNs) at VA medical facilities to ensure their health care professionals are practicing at the full scope in their field of practice.*
- *growing the existing Memorandum of Understanding (MOU) between the VHA and the Department of Health and Human Services from 30 to over 100 billets for members of the U.S. Public Health Service (USPHS) to serve in clinical and non-clinical roles.*
- *establishing an MOU between VHA and USPHS to create and fund 10 slots per year at the Uniformed Services University of the Health Sciences for medical students who agree to join USPHS and then serve in VHA clinics and hospitals to repay the government for their medical education.*

CHAMPVA YOUNG ADULT

When the Patient Protection and Affordable Care Act (ACA) became law in 2010, ACA required health insurance plans to provide dependent coverage of children, and to continue to make such coverage available for an adult child until age 26. Private-sector insurance and DoD TRICARE

insurance plans conform to the law, however the authorizing statute for CHAMPVA has yet to conform to the ACA requirement.

The association once again is seeking legislation, as has been offered in previous sessions of Congress, to allow children eligible for CHAMPVA to maintain their coverage until their 26th birthday, bringing the program in line with private insurance plans and DoD's TRICARE Program. A child would be ineligible for CHAMPVA if he or she is eligible for coverage in an employer-sponsored health care plan. Those eligible would include adult children of:

- veterans rated permanently and totally disabled for a service-connected disability;
- veterans who have died from service-connected disabilities;
- veterans who are totally disabled from a service-connected disease at the time of their death; and
- military members who have died in the line of duty.

MOAA urges Congress to expand CHAMPVA to include children of eligible veterans, family members, and survivors until age 26 to align eligibility with TRICARE Young Adult and private-sector health insurance plans.

BEHAVIORAL HEALTH AND WELL-BEING

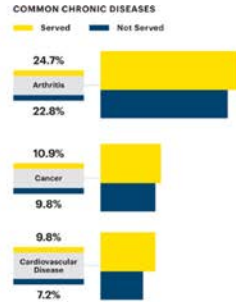
For nearly four years, MOAA has partnered with the United Health Foundation (UHF) with the goal of determining how the unique demands of military service could affect long-term health so research and public policy can be directed toward understanding and improving these factors and conditions.

Last year's national study revealed those who have served are more likely to describe their health as "good" or "excellent," than their civilian counterparts — but they're also more likely to suffer from a litany of chronic diseases and to engage in unhealthy behaviors.

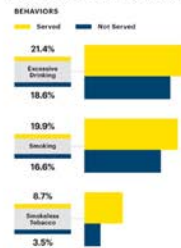
The 2018 *America's Health Rankings Health of Those Who Have Served Report* captures trends over six years, comparing recently available 2015-2016 data to a baseline of 2011-2012 data¹³. Some of the findings:

- Those who have served are more likely to have cancer (10.9 percent, compared with 9.8 percent of civilians), cardiovascular disease (9.8 percent to 7.2 percent), and arthritis (24.7 percent to 22.8 percent) than their civilian counterparts.

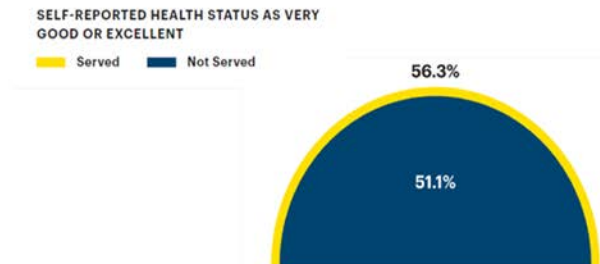
¹³<https://www.americashealthrankings.org/learn/reports/2018-health-of-those-who-have-served-report>



- Those who have been in uniform reported higher rates of excessive drinking (21.4 percent, compared with 18.6 percent of civilians), smoking (19.9 percent to 16.6 percent) and insufficient sleep (42.5 percent to 34.6 percent) than civilians, as well as more than double the rate of smokeless tobacco use (8.7 percent to 3.5 percent).



- Despite the above, 56.3 percent of those who have served reported being in good or excellent health, compared with 51.1 percent of those who didn't serve.



Those who have served also show a tendency to engage in preventive health care services at a higher rate than their civilian counterparts, with more of them visiting the dentist (69.6 percent,

compared with 65.2 percent of civilians), getting a flu vaccine (50.6 percent to 37 percent), and undergoing a colorectal cancer screening (72.4 percent to 66 percent).

The report compared its survey findings with a similar survey from 2011-2012. Those comparisons showed some improvements in key health areas among those who've served: declines in excessive drinking and smoking, for instance, and greater access to health insurance.

It also showed some troubling trends, particularly among women who've served: Their rates of suicidal thoughts more than tripled, for example, from 1.8 percent in 2011-12 to 7 percent in 2015-16.

These trends from the UHF-MOAA studies and other reports are concerning and highlight the need for a greater national engagement strategy to address these frightening statistics.

MOAA and other VSO stakeholders continue to highlight the need to strengthen VA and DoD collaboration and services by fully implementing and sustaining an integrated, multidisciplinary, biopsychosocial, comprehensive behavioral health system, incorporating traditional and nontraditional prevention and treatment protocols to address the rising rates of suicides and growing numbers of servicemembers, veterans, and family members suffering from pain and traumatic injuries.

There is no doubt VA has made great strides in expanding its health care services to help veterans with mental health conditions, including providing emergency care to veterans discharged under other-than-honorable conditions who normally are not eligible for VA benefits, expanding telemental health services, and advancing complementary and integrative health treatments to promote self-help and healing and supplement traditional medical approaches.

While efforts so far are promising, there is evidence indicating big gaps still exist in how VA is delivering the kind of wrap-around services and continuity of care to veterans suffering from mental health issues or exposed to traumatic injuries. According to VA, only around 1.3 million (of the almost 22 million veterans in the U.S.) receive specialized mental health treatment from VA for mental health related issues;¹⁴ clearly much more work is needed in outreach and educating veterans about the services available in VHA.

A January 2018 congressionally mandated report¹⁵ by the National Academy of Sciences, Engineering and Medicine also corroborates the notion that a significant number of Iraq and Afghanistan veterans were unaware of the services in VHA or didn't know how to access care. VA also must continue to work with Congress to look for innovative solutions for hiring additional providers and expanding services to meet the growing demand and needs of high-risk veteran

¹⁴ https://www.va.gov/opa/issues/mental_health.asp

¹⁵ National Academy of Sciences Health and Medicine Division, January 31, 2018: Evaluation of the Department of Veterans Affairs Mental Health Services, <http://nationalacademies.org/hmd/Reports/2018/evaluation-of-the-va-mental-health-services.aspx>

populations with debilitating issues associated with homelessness, military sexual assault, chronic medical conditions, drug and alcohol abuse, brain or traumatic injuries, and suicidal ideation.

MOAA recommends:

- *investing in programs and research to identify and treat at-risk populations and leverage the VA-DoD electronic health record to complement data collection, prevention, and treatment strategies to promote mental health and well-being and eradicate suicides.*
- *monitoring VA Suicide Prevention Office efforts to increase behavioral health staff, resources, and crisis line capacity, ensuring outreach efforts are expanded and synchronized with the DoD Suicide Prevention Office to address the high rates of suicide among servicemembers and veterans, ensuring every call to the VA or military crisis lines is promptly answered.*
- *monitoring VA and DoD outreach and policy efforts to address mental health needs of veterans with other-than-honorable discharges.*
- *expanding evidence-based and complimentary-integrative medical treatment approaches to improve delivery of care.*
- *investing in resources and programs to aggressively promote prevention before crisis, incorporating self-help tools and services for empowering, educating, and engaging veterans' involvement in managing their individual health care outcomes.*
- *evaluating the Department of Health and Human Services' Pain Management Best Practices Inter-Agency Task Force (Task Force Report recommendations to be published in May 2019) to identify opportunities to eliminate gaps and improve VA-DoD pain-management programs and medication-assisted treatments, including opioid treatment, mental health, and suicide prevention programs.*

WOMEN VETERANS' HEALTH CARE

Women continue to enter military service in record numbers. Over the next 10 years the total population of women veterans is expected to increase at a rate of about 18,000 women each year.¹⁶ VA continues to struggle to adapt and grow to meet the rising demand in delivering health care and benefits to this diverse veteran population.

The elimination of combat exclusion policies regarding women in 2015 set a new course for women in military service and presents new challenges and opportunities for collaboration between VA and DoD. More research will be needed to better understand the impact of military service on women's health, as well as new treatments and ways to deliver care to meet their unique health needs. Both health systems must be prepared to address not only the most pressing medical conditions and needs women face today but also the unique and evolving health issues associated with women serving in combat.

¹⁶ Department of Veterans Affairs National Center for Veterans Analysis and Statistics, February 2017, Women Veterans Report: The Past, Present and Future of Women Veterans, https://www.va.gov/vetdata/docs/SpecialReports/Women_Veterans_2015_Final.pdf

An earlier study in November 2017, when MOAA again partnered with the UHF, called, the *America's Health Rankings® Health of Women Who Have Served Report*,¹⁷ found women veterans reported higher rates of cancer, mental illness, chronic obstructive pulmonary disease (COPD), and depression. This distinctive study, developed in collaboration with an advisory steering group of leading military, veterans', and public health organizations, including VA, establishes a baseline portrait of the health of women who have served in the U.S. armed forces compared to the health of their civilian counterparts.

Year after year, we hear of the substantial amount of work VA has done to encourage women veterans to "choose VA" for their health needs by reducing gender gaps in clinical care and expanding services and care across the country. However, a number of significant barriers still linger, as pointed out in recent Government Accountability Office (GAO) high-risk studies¹⁸ and ongoing reports by VA's Advisory Committee on Women Veterans¹⁹.

MOAA is grateful for the committees' efforts in recent years to address these lingering barriers and willingness to ensure women veterans have equal access to medical and other benefits. Legislative initiatives put forth in the previous Congress, such as the Deborah Sampson Act, sponsored by Senator Tester and Representative Esty, and the efforts of Chairman Takano and Representative Brownley this year in establishing a women veterans task force, must aggressively continue if we are to break down these barriers so they can get the medical treatment and services they have earned through their service.

MOAA recommends:

- *enacting the House-passed H.R. 95 bill, the Veterans' Access to Child Care Act, directing VA to provide child care assistance to an eligible veteran for any period the veteran receives health care services in a VA facility and is required to travel to and from the facility for such care.*
- *aggressively investing and implementing VA's Strategic Priorities to provide comprehensive primary care, health education, and reproductive health services; improve communication and partnerships; and increase access to gender-specific medical and mental health care to meet the unique needs of women servicemembers and transitioning women veterans. Ensure emphasis on programs for women veterans with special needs, including rural, homebound, and aging veterans, as well as women who have lost limbs.*
- *ensuring VA transformational changes such as the VA MISSION Act, community care, and other health and benefit programs and support service reforms consider the impact of change on women veterans and include their perspective in VA system changes.*
- *assessing current research, studies, and treatments being used to address the higher rates of mental health and suicidal ideation among women who have served, and requiring VA to establish a comprehensive strategy and prevention plan for incorporating*

¹⁷ http://www.moaa.org/uploadedFiles/Content/Take_Action/Womens_Health_Report/hwwhs17_final.pdf

¹⁸ <https://www.gao.gov/assets/690/682765.pdf>

¹⁹ <https://www.va.gov/womenvet/docs/acwv/acwvReport2016.pdf>

evidence-based approaches and practical, wrap-around, gender-specific health care programs and services to meet the unique needs of women veterans.

- *directing VA to produce a report regarding disability compensation claims filed by women veterans compared to male veterans to determine whether there is a disparity between the disability ratings awarded to women versus men for the same conditions.*
- *the committees conducting a joint oversight hearing with the Armed Services committees to review how the unique needs of women transitioning from active duty to veteran status are addressed and can be improved upon.*

SERVICE-CONNECTED ILLNESSES AND ENVIRONMENTAL EXPOSURES

With greater emphasis on psychological and physical health care, including veterans exposed to toxic substances, environmental hazards and catastrophic injuries during military service, the need for long-term disability care and support services will rise with the aging veteran population.

Reports like the UHF-MOAA *Health of Women Who Have Served* and the *Health of Those Who Have Served Reports* continue to raise questions about what might be contributing to key differences in the health of our servicemembers and veterans, such as higher rates of several chronic diseases, cancer, coronary heart disease, and heart attacks than are seen in their civilian counterparts. A growing body of evidence and reports indicate more documentation, research, and treatment solutions are needed to address the growing number of veterans coming forward with conditions for which they are unable provide evidence to support their claim of service-connection.

It is time for Congress to establish standing policies and procedures for addressing these and future toxic and environmental exposures so veterans no longer need to fight each battle individually. This can be accomplished through legislation addressing current veterans who have suffered exposures to provide proper presumptions to facilitate them being awarded health care and disability compensation, as well as legislation establishing a process moving forward for those who might be exposed to as yet unidentified toxins or environmental hazards.

Congress also must require VA to use that information to establish benefits for those conditions and not require each individual veteran to scientifically prove exposure-related ailments with each claim made. It is inefficient, ineffective, and unreasonable to place the burden on veterans to provide scientific and medical evidence for each claim when such expertise necessarily resides within the government itself.

Here's one currently serving MOAA member's story of his father's difficulties in proving service connection — difficulties that impact this servicemember's perception of VA:

My father served as a U.S. Army finance officer from June 1973-June 2001. He died from brain cancer on September 28, 2007, at the age of 56. He served in Desert Shield/Desert Storm as part of the 7th Finance Group, which was under VII Corps. Around the time of his retirement he received a note from the VA that several units had personnel who were dying at an abnormally high rate from brain related issues. His was one of those units...

Ultimately the claim for cancer was denied because it was more than one year after he retired and we could not prove sarin exposure was a carcinogen. I do think it was a direct cause and, both correlation and causation.

The care he received from providers, doctors, and nurses, and staff was great. The bureaucracy was not. After his brain surgery, the steroids he took for brain swelling caused his intestines to rot and burst. He was admitted to the ER and after an emergency surgery and short stay he was discharged. He could not heal. He was subsequently readmitted but needed hospice. At that point there were no programs for veterans under the age of 65 who needed hospice. It took the director of the Indianapolis VA to authorize hospice because they use supplemental insurance (Medicare) to pay for hospice, listed on their website under geriatric care...

The providers and staff are awesome and care for veterans like no other. I see concerns in lag between discharge from service and VA taking over health care...While it seems the newer processes are speeding up ratings and the like, the bureaucracy continues.

Major, USA

MOAA urges Congress to support medical research to determine the impact of servicemembers exposed to occupational or environmental toxins or other hazardous substances resulting from their military service assignments in or outside of the U.S. Also, MOAA asks Congress to ensure health care and benefits are established to appropriately compensate and support veterans and family members, including children and survivors, particularly of veterans who experience catastrophic and devastating cancers, diseases, illnesses, or other health conditions, or death.

Specifically, MOAA recommends:

- *enacting Agent Orange and Burn Pit legislation—H.R. 299/203, H.R. 1005, S. 191/H.R. 663, and H.R. 637.*
- *allowing surviving family members to add deceased veterans to the Burn Pit or other established registries.*
- *requiring DoD-military services to formulate a strategy and implementation plan incorporating protocols for establishing baseline health assessments and collecting military service assignment, deployment, military history, and other appropriate medical-personnel data at the point of entry into military service and at regular intervals throughout military service.*
- *requiring VA-DoD to establish standard data elements and procedures, leveraging the departments' electronic health record platform as the official data management system for collecting, retrieving, and managing military assignment, deployment, military history, and other appropriate medical-personnel data needed to provide health care and benefits to veterans and uniformed servicemembers and their families.*
- *the committees conducting a joint oversight hearing with the Armed Services committees to review current data collection and information sharing between VA and DoD related to military service, including scope of medical conditions and discharges for disabilities, diseases, and illnesses, and to identify trends and opportunities to improve data management and medical and benefit programs for current and future exposures.*

VETERANS' BENEFITS PRIORITIES

PRESERVE THE INTEGRITY OF VETERANS' EARNED BENEFITS

MOAA's overarching priority is to preserve the integrity of veterans' earned benefits, ensuring those who are serving and those who have served are able to access their service-earned benefits in a timely manner.

Like VHA, VBA has undergone major changes in recent years. MOAA is grateful for the committees' partnership in championing major reforms to improve veterans and survivor education benefits, notably the Forever GI Bill, as well as legislation to streamline and modernize the claims and appeals process, as in the Veterans Appeals Improvement and Modernization Act.

Implementing these massive reforms presents major challenges for VBA, as we've seen in recent months with technology glitches rolling out the Forever GI bill.

MOAA will continue to closely monitor implementation of VBA reforms and press for more transparency, oversight, and accountability throughout execution.

MOAA extends a special thanks to the leadership of the committees for your commitment in picking up where we left off in the 115th Congress and doing what it takes to get the Blue Water

Navy Vietnam Veterans Act enacted this year. We are grateful for Chairman Takano and Ranking Member Roe leading off with the introduction of H.R. 299 and H.R. 203. In addition, we are appreciative of the committees' pledged commitment to streamlining processes and protocols for determining toxic and environmental exposures to establish presumptive service conditions, and we look forward to working together to streamline and enhance delivery of veterans benefits.

MOAA recommends:

- *enacting the Blue Water Navy Vietnam Veterans Act.*
- *continuing congressional oversight efforts on VA's implementation of the Forever GI Bill to ensure Congress' intent is being met by the quality of educational institutions being funded by the GI Bill, including positive student-veteran outcome measures.*
- *introducing and passing legislation to align VA protections for student-veterans with Department of Education and DoD protections.*
- *integrating VA and DoD Disability Evaluation Benefit Systems to achieve true interoperability of electronic medical, personnel, and benefit records to improve medical outcomes and delivery of benefits.*
- *Strengthening the VA Vocational Rehabilitation and Employment (VRE) program to provide consistent and predictable benefits for veterans with disabilities. Establish a cost-of-living stipend for VRE participants.*

CONCLUSION

In closing, it is important to reinforce three key messages from our testimony today:

- Recent major reforms are monumental, massive, and extremely complex, and we can expect challenges during implementation. VA must receive the time and tools it needs to implement these reforms.
- There should be more collaboration between VA and DoD, as well as joint hearings between the Veterans' Affairs and Armed Services committees on important issues such as toxic exposure, women veterans, the electronic health record, and mental health and suicide prevention.
- Safeguarding and improving timely access to service-earned VA benefits and health care are paramount to MOAA and veterans and their families.

MOAA looks forward to working with the committees to ensure VA has what it needs to implement these reforms and help the department continue down the path of building a VA all veterans can be proud to call their own.



Biography of René Campos, CDR, USN (Ret)
Senior Director, Government Relations for Veterans-Wounded Warrior Care

Commander René Campos serves as the Senior Director of Government Relations, managing matters related to military and veterans' health care, wounded, ill and injured, and caregiver policy.

She began her 30-year career as a photographer's mate, enlisting in 1973, and was later commissioned a naval officer in 1982. Her last assignment was at the Pentagon as the associate director in the Office of Military Community and Family Policy under DoD Personnel and Readiness.

Commander Campos joined MOAA in October 2004, initially helping to establish a military family program working on defense and military quality-of-life programs and readiness issues. In September 2007, she joined the MOAA health care team, specializing in Veterans and Defense health care systems, as well as advocating for wounded warrior care and women military-veteran policies and programs.

Commander Campos serves as a member of The Military Coalition (TMC) — a consortium of nationally prominent uniformed services and veterans' organizations, representing approximately 5.5 million current and former members of the seven uniformed services, including their families and survivors, serving as the cochair on the Veterans Committee and as a member of the Health Care, Guard and Reserve, and Personnel, Compensation and Commissary committees.

MOAA Testimony Points

- Encourage Congress to invest in modernization of VHA technology, financial, infrastructure, electrical health record, and human resource systems.
- Desire Congress to Implement independent practice authority for advance practice nurses (APRNs) at VA medical facilities.
- Desire Congress to grow the existing Memorandum of Understanding (MOU) between the VHA and the Department of Health and Human Services to serve in clinical and non-clinical roles.
- Desire Congress to Establish an MOU between VHA and US Public Health Service (USPHS) to create and fund slots at the Uniformed Services University for medical students who join USPHS and serve in VHA clinics and hospitals to repay the government for their medical education.
- Urge Congress to expand CHAMPVA to include children of eligible veterans, family members, and survivors until age 26.
- Encourage Congress to enact *H.R. 95, the Veterans' Access to Child Care Act*.
- Encourage Congress to implement VA's *Strategic Priorities*.
- Encourage Congress to ensure VA changes such as *the VA Mission Act*.
- Desire Congress to direct VA to produce report for disability compensation claims filed by women veterans and whether there is disparity between genders for the same conditions.
- Desire Congress to conduct oversight of the needs of women transitioning from active duty to veteran status.
- Desire Congress to enact *Agent Orange and Burn Pit Legislation, H.R. 299/203, H.R. 1005, S. 191/H.R. 663, and H.R. 63*.
- Request Congress to allow surviving family members to add deceased veterans to Burn Pit or other established registries.
- Request Congress to require DoD-military services to develop strategy for implementing military and medical-personnel data at entry into service and regular intervals throughout service.
- Request Congress to require VA-DoD to establish data elements and procedures to facilitate health care and benefits to veterans and their family members.
- Request Congress to enact *Blue Water Navy Vietnam Veterans Act*.
- Request Congress to continue oversight of VA's implementation of *Forever GI Bill*.
- Request Congress to pass legislation to align VA protection of student veterans with Department of Education and DoD protections.
- Request Congress to integrate VA and DoD Disability Evaluation Benefits Systems.
- Request Congress to strengthen VA Vocational Rehabilitation and Employment (VRE) program and establish cost-of-living stipend for VRE participants.

STATEMENT FOR THE RECORD
to the
Senate Veterans' Affairs Committee and House Veterans' Affairs Committee
Joint Hearing
To Receive Legislative Presentations of Veterans Service Organizations

By

Jan Thompson

President
American Defenders of Bataan and Corregidor Memorial Society

12 March 2019

AMERICAN PRISONERS OF WAR OF JAPAN
CEMENTING A LEGACY

Chairmen Isakson and Takano, Ranking Members Tester and Roe, and Members of the Senate and House Veterans Affairs Committees, thank you for allowing us to describe how Congress can meet the concerns of veterans of World War II's Pacific Theater. The American Defenders of Bataan and Corregidor Memorial Society (ADBC-MS) represents surviving POWs of Japan, their families, and descendants, as well as scholars, researchers, and archivists. Our goal is to preserve the history of the American POW experience in the Pacific and to teach future generations of the POWs' sacrifice, courage, determination, and faith—the essence of the American spirit.

Today, I want to speak to you about what it means to “Never Forget” our veterans. The men and women who became POWs of Japan over 70 years ago fought the early desperate battles of WWII in the Pacific and suffered some of its worst consequences. Nearly 40 percent did not return home. Those who survived had the highest rate of post-conflict hospitalizations, deaths, and psychiatric disorders of any generation of veterans. Their families endured and inherited their trauma.

If this history is forgotten, so too will the sacrifices of today's veterans. It is an obligation to honor our veterans and to remember appropriately their contribution to our country's history.

Before the last American POW of Japan dies, we believe that the appropriate civic remembrance for them is a Congressional Gold Medal that recognizes their unique history of perseverance, valor, and patriotism.

Our history

On December 7, 1941, Imperial Japan attacked not only Pearl Harbor but also the Philippine Islands, Guam, Wake Island, Howland Island, Midway, Malaya, Singapore, Thailand, Hong

Kong, and Shanghai. Three days later, Guam became the first American territory to fall to Japan. At the same time, the U.S. Far East Air Force on the Philippines was destroyed. By March 1942, Imperial Japanese Armed forces had destroyed the U.S. Asiatic Fleet in battles off Java.

Although the aim of the December 7th surprise attack on Hawaii's Pearl Harbor was to destroy the U.S. Pacific Fleet in its home port and to discourage U.S. action in Asia, the other strikes served as preludes to full-scale invasions and military occupation. Starting with the China Marines on December 8th, Americans throughout the Pacific became prisoners of war.

Only in the Philippines did U.S.-Filipino units mount a prolonged resistance to Imperial Japan's invasion. They held out for five months. Help was never sent. They were abandoned. On April 9, 1942, approximately 10,000 Americans and 70,000 Filipinos became POWs with the surrender of the Bataan Peninsula. April 9th also marked the beginning the 65-mile Bataan Death March. Thousands died and hundreds have never been accounted for from the March and its immediate aftermath.

By June 1942, most of the estimated 27,000 Americans ultimately held as military POWs of Imperial Japan had been surrendered. If American civilians in Japan, the Philippines and throughout the Pacific held as POWs or internees are also counted, this number is closer to 36,000. Nearly all remained captives until the end of the war. The Japanese paroled Filipino soldiers in June 1942. By the War's end, 40 percent or over 12,000 Americans had died in squalid POW camps, in the fetid holds of "hellships," or in slave labor camps owned by Japanese companies.

Surviving as a POW of Japan was the beginning of new battles: finding acceptance in society and living with serious mental and physical ailments. In the first six years after the war, deaths of American POWs of Japan were more than twice those of the comparably aged white male population. These deaths were disproportionately due to tuberculosis, suicides, accidents, and cirrhosis. In contrast, 1.5 percent of Americans in Nazi POW camps died (as noted above as the mortality rate for POWs of Japan was 40 percent) and in the first six years after liberation Nazi POW camp survivors deaths were one-third of those who survived Japanese POW camps.

Supporting today's veterans

As the representative of veterans who faced often-insurmountable challenges obtaining adequate healthcare for their exotic ailments and severe PTSD, we are especially supportive of the DAV's efforts to expand healthcare for all service-related illnesses and mental health.

We were delighted to see the May 2018 passage of the VA MISSION Act of 2018 (Public Law 115-182), which contains provisions to support family caregivers of veterans severely injured before September 11, 2001. We join with the DAV in calling on Congress and the VA to further expand this program to include not just severely injured veterans, but also veterans whose serious disabilities were caused by service-connected illnesses. My veterans often suffered debilitating illnesses from the residue effects of vitamin deficiency, beatings, and exposure to dangerous toxins in lead and coal mines as well as chemical factories in Japan.

Progress Toward Remembrance, Reconciliation, and Preservation

An essential element of showing respect and acceptance to today's servicemen and women is to ensure that they are not forgotten. This is the primary mission of the ADBC-MS. To this end, we have had a number of significant achievements in the last decade.

In 2009, the Government of Japan, through its then-Ambassador to the U.S. Ichiro Fujisaki (today an Outside Director to Nippon Steel & Sumitomo Metal Corporation), and again in 2010, through its then-Foreign Minister Katsuya Okada, issued an official apology to the American POWs of Japan. These Cabinet-approved apologies, first established as a Cabinet Decision on February 6, 2009, were unprecedented. Never before had the Japanese Government apologized for a specific war crime, nor had it done so directly to the victims.

The Japanese Government in 2010 initiated the "Japan/POW Friendship Program" that sponsors trips for American former POWs to visit Japan and return to the places of their imprisonment and slave labor. Thus far, there have been 10 trips, one each in the fall of 2010, 2011, 2012, 2013, 2014, and two in 2015, one in 2016, 2017, and 2018. In 2016 and 2018, due to the advanced age of surviving POWs, only widows and children participated in the program. In all, 46 former POWs, all in their late-80s or 90s, as well as nine widows and ten children have made the trip to Japan. A number of the caregiver companions were wives, children, and grandchildren.

The year 2015, the 70th anniversary of the end of World War II, was particularly significant. Our last National Commander, the late Dr. Lester Tenney, was invited to witness Prime Minister Shinzo Abe's address to a joint meeting of Congress and to join at his celebratory gala dinner at the Smithsonian, where the Prime Minister offered his personal apology. Significantly, that day, April 29th, was also the reinstated birthday holiday of the wartime Emperor Hirohito. Later that year, Dr. Tenney was a guest of President Barack Obama at the White House's (then) annual Veterans' Day breakfast.

On July 19, 2015, the Mitsubishi Materials Corporation (MMC) became the first, and remains the *only*, Japanese company to officially apologize to those American POWs who were used as slave laborers to maintain war production. Former diplomat, Yukio Okamoto, a member of MMC's board, helped facilitate this act of contrition. The historic apology was offered to the 900 Americans who were forced to work in four mines operated by Mitsubishi Mining, Inc., the predecessor company of MMC. This apology was followed by a \$50,000 donation to the National American Defenders of Bataan & Corregidor (ADBC) Museum, Education & Research Center in Wellsburg, West Virginia.

The leaders of both Japan and the United States acknowledged the American POWs and their contribution to the steady relationship between two countries in their war anniversary speeches. In his September 2nd VJ day statement, President Obama echoed President Harry Truman and remembered "those who endured unimaginable suffering as prisoners of war." Japanese Prime Minister Shinzo Abe in his war anniversary statement on August 14th recognized "the former POWs who experienced unbearable sufferings caused by the Japanese military."

On May 27, 2016, President Barack Obama journeyed to Hiroshima, the site of the first atomic bombing, to become the first American president to mourn the dead and grieve with the living.

There, as shown in a widely published photograph, the President embraced a survivor who had dedicated the greater part of his life to discovering the identities and honoring the memory of twelve American POWs who perished in Hiroshima.

In November 2016, a former POW of Japan, Airman Dan Crowley of Connecticut, was a guest at President Obama's last Veterans' Day breakfast. On December 28th, the ADBC-MS vice president Nancy Kragh and I were guests of the President to witness Prime Minister Abe's condolences at Pearl Harbor.

In August 2018, another historic ceremony was held in Hawaii remembering Pacific War veterans and POWs. After years of Department of Veterans Affairs cemetery administrators' objections to the use of "hellship" for the Japanese ships transporting POWs—they felt it might offend some tourists—the Department approved our application for a memorial stone for the 400 POWs buried as unknowns in the National Memorial Cemetery of the Pacific. The men died on January 9, 1945, in the sinking by American bombers of the hellship *Enoura Maru* in Takao Harbor, Formosa (today's Taiwan). Unknown to their families until 2001, their remains had been retrieved in 1946 and moved to Hawaii.

We thank Under Secretary for Memorial Affairs of the Department of Veterans Affairs Randy Reeves, Executive Director for Cemetery Affairs Lisa Pozzebon, and my Congressman Mike Bost, who is the ranking member of the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs, for their help and for understanding that "hellship" has been the term used since the Revolutionary War to describe the squalid vessels that held prisoners of war.

Over 100 family members, representatives of veterans' organizations, and the U.S. Indo-Pacific Command, attended the August 15th ceremony at the National Memorial Cemetery of the Pacific to dedicate our memorial stone to the POWs on the *Enoura Maru* and to identify the men in graves marked "unknowns." Diplomats and military officials from the United Kingdom, Australia, Canada, the Netherlands, Norway, and the Czech Republic—countries that all had citizens who were POWs aboard the *Enoura Maru*—also participated. The Japanese consul general and the director general of the Taiwan Economic Cooperation Office were included. BGen Thomas Tickner, Commanding General, Pacific Ocean Division, U.S. Army Corps of Engineers was the senior military official to address the gathering.

Success should encourage more action

The benefits of Japan's long-awaited acts of contrition have been immeasurable for former POWs and their families. The visitation program is a great success. It has given the participating veterans a peace of mind and their families a connection to their fathers' challenges. For the Japanese people touched by these visits it is often their first introduction to the non-Japanese victims of the Pacific War.

But we are concerned for the future. There is no formal agreement between the U.S. and Japan to continue the visitation program, and Japan's Foreign Ministry must request annually its line-item in the budget. We know that despite the tens of millions of dollars being expended by Japan on

“Takehashi” exchange programs in the United States, the funds for the POW Friendship exchanges have been slashed. There is the possibility that the program may end altogether.

This is profoundly shortsighted. And it is something that should worry Members of Congress. Our relationship with such an important ally can only strengthen through reconciliation efforts. History does not end when the last witness dies. The proliferation of revisionist history in Japan is cause enough to encourage greater work to tell a multi-faceted history of the Pacific War.

For the POW families, it is clear that a POW’s cruel captivity was not merely an individual trauma—the pain has spanned several generations. The wives, children, and siblings of those who died suffered irreparable loss. The families of those who returned home became caregivers to survivors who suffered from long-term physical and mental health problems. Further, new research has found that trauma changes one’s DNA, which is then passed on to the victim’s progeny.

History Revisionists

To our dismay, many in Japan – including elected leaders – are actively revising if not denying the history of American POWs. For example, last year the Japanese press stopped using the expression “forced labor” to describe the Koreans requisitioned by the Japanese late in the war and, thus, implicitly the POWs. The sites of Japan’s “Meiji Industrial Revolution: Iron and Steel, Shipbuilding and Coal Mining” on the UNESCO World Industrial Heritage list continue to ignore the POW slave labor there. In five of these eight new World Heritage areas there were 26 POW camps that provided slave labor to Japan’s industrial giants including Mitsui, Mitsubishi, Sumitomo, Aso Group, Ube Industries, Tokai Carbon, Nippon Coke & Engineering, Nippon Steel & Sumitomo Metal Corporation, Furukawa Company Group, and Denka.

Many of the 60 companies that requested and acquired POW slave laborers during the War still exist and are members of Japanese consortia—headed by JR East and JR Central—that want to participate in high-speed rail and other infrastructure projects in the United States. Neither has acknowledged or apologized for their use of POW slave labor. By contrast, their competitors on these very projects – the French (SNCF) and the Germans (Siemens)—have been held accountable for similar behavior in Europe during WWII.

It is also unsettling that no one has objected to the selection of Osaka as the host city for the G20 leaders’ summit in 2019 and of Fukuoka as the venue for the meeting of G20 finance ministers and central bank governors. Osaka will also be the site for the world Expo 2025. These internationally forward-focused events contrast sharply with the parochial, anachronistic views of the city’s leaders.

The recent mayors of Osaka have distinguished themselves as outspoken deniers of Pacific War history—even ending the sister city relationship with San Francisco over the American city’s refusal to remove a war memorial and rejection of the Osaka mayors’ false and pernicious construction of the war’s history.

Osaka and Fukuoka were areas of the greatest number of slave labor camps using American and Allied POWs in mines, factories, mills, and on docks, many of which have become UNESCO

World Industrial Heritage sites. It was at Fukuoka prefecture's Port of Moji where most of the POWs arrived in Japan. Fukuoka's international airport was originally an Imperial Army airfield (Mushiroda Airfield) built by British, Dutch, and American POWs. In Fukuoka, eight American aviators were vivisected at the local university. Hours after the Emperor declared the war over, seventeen Americans were beheaded on the slopes of the city's Mt. Abura.

We object strongly to American participation in any conference or Expo held by a city that publicly and willfully denies the established historical record and embraces a discredited, dishonest, and indecent historical narrative.

Only an active, ongoing, and public program of remembrance and education will guarantee Japan not falling into moral complacency.

What we ask Congress

We ask Congress to encourage the Government of Japan to hold to its promises and responsibilities by preserving, expanding, and enhancing its reconciliation program toward its former American prisoners. We want to see the trips to Japan continued. We want Japan's Ministry of Foreign Affairs to publicize the program, its participants, and its achievements. We want to see a commitment to remembrance. We believe that both countries will be stronger the more we examine our shared history.

We ask Congress to encourage Japan to turn its POW visitation program into a permanent Fund supported by Japanese government and industry. This "Future Fund," not subject to Ministry of Finance yearly review, would support research, documentation, reconciliation programs, and people-to-people exchanges regarding Japan's history of forced and slave labor during WWII. Part of the Fund's educational programming would be the creation of visual remembrances of this history through museums, memorials, exhibitions, film, and installations. Most important, the Fund would support projects among all the arts from poetry, literature, music, dance, and drama to painting, drawing, film, and sculpture to tell the story to the next generation.

We ask Congress to ask and to instruct the U.S. State Department to continue to represent rigorously the interests of American veterans with Japan. It is only the U.S. government that can persuade Japan to continue the visitation program, to create a Future Fund, and to ensure that the Sites of Japan's Meiji Industrial Revolution include the dark history of POW slave labor.

We ask Congress to press the Japanese government to create a memorial at the Port of Moji, where most of the "Hell ships" docked and unloaded their sick and dying human cargo. The dock already features memorials to the Japanese soldiers and horses that departed for war from this port. Nowhere in Moji's historic district is there mention of the captive men and looted riches off-loaded onto its docks. This must change.

The Congressional Gold Medal

Most important, we ask Congress to approve an accurate and inclusive Congressional gold medal for the American POWs of Japan. It is a long overdue symbol of our commitment to veterans of past generations that we will "never forget."

Over the past few years, there have been Congressional gold medals given to groups that included American POWs of Japan. Eight members of the Doolittle Raiders were POWs, at least one Nisei member of the Military Intelligence Service was a POW, and nearly all the officers of the Filipino troops who were awarded Congressional Gold Medals were American.

Unlike previous WWII Congressional Gold Medal award groups that honor specific service units or ethnicities, the American POWs of Japan are both men and women from many ethnic groups, religions, services, and regions. For example:

- The 200th Coast Artillery (AA) on Bataan, the first to fire on the invading Japanese forces, was composed mainly of Hispanic Americans from New Mexico.
- The first tanker to die in WWII was Private Robert Brooks, a black man with the 192nd Tank Battalion from Harrodsburg, Kentucky, who was killed on Nichols Field, Philippines.
- Chinese-American, Eddie Fung, and Japanese-American, Frank Fujita, both fought on Java and were surrendered with the U.S. Army 2nd Battalion, 131st Field Artillery, 36th Division (Texas National Guard).
- A statue before the St. Landry Catholic Church in Opelousas, Louisiana memorializes Army Air Corps Chaplain Father LaFleur who sacrificed his life while saving fellow POWs in the sinking of the hellship *Shinyo Maru*.
- The military nurses captured in the Philippines were the first large group of American women in combat and, counted with the Army and Navy nurses surrendered on Guam, comprised the first group of American military women taken captive and imprisoned by an enemy.
- Over 600 United States Merchant Marines, including one woman Mariner, became prisoners of Imperial Japan. Fifteen percent were killed by Japanese Imperial Navy officers during capture or died in Japanese POW camps.
- The first American POWs of Japan were Marines stationed in China and the last were Navy and Army aviators shot down over Japan.
- An Army Corps of Engineers Master Sergeant, Aaron Kliatchko, who died aboard a hellship is remembered as the “Rabbi of Cabanatuan” POW camp in the Philippines where he consoled Jew and gentile alike.

Seventy-eight years after the start of the War in the Pacific, it is time to recognize *all* those who fought the impossible and endured the unimaginable in the war against tyranny in the Pacific. Moreover, as I have described above, the Gold Medal would also recognize that we are the only American wartime group to have negotiated our own reconciliation with the enemy.

High price of freedom

The American POWs of Japan and their families paid a high price for the freedoms we cherish. In return for their sacrifices and service, they ask that their government keep its moral obligation to them. They do not want their history ignored or exploited. What they want most is to have their government stand by them to ensure they will be remembered, that our allies respect them, and that their American history be preserved accurately for future generations.

Our history is one of resilience, survival, and the human spirit, good and bad. And it has become an example of a path toward reconciliation and justice between Japan and its former victims.

We ask Congress for support and to help our veterans in their unique quest for justice and remembrance. Congress needs to encourage Japan to do more toward reconciliation and considering its past truthfully. Congress can cement our past in the national history with the awarding of a Gold Medal.

In the United States Pacific War history is being forgotten, and in Japan it is being revised. We cannot let this happen.

It is not enough that National Prisoner of War Remembrance Day is April 9, 1942, which marks the Fall of Bataan and the start of the infamous Bataan Death March.

Congress needs to embed this remembrance into the body politic with a gold medal.

Thank you for this opportunity to address your committee.

Ms. Jan Thompson

President

American Defenders of Bataan & Corregidor Memorial Society

Daughter of PhM2c Robert E. Thompson USN, USS *Canopus* (AS-9)

Survivor of the hellships *Oryoku Maru*, *Enoura Maru*, and the *Brazil Maru*

Bilibid, Fukuoka 3B, & Mukden, POW# 2011

<http://dg-adbc.org/>



OFFICIAL STATEMENT OF

**KEITH A. REED, MSGT, USAF, RETIRED
EXECUTIVE DIRECTOR
AIR FORCE SERGEANTS ASSOCIATION**

**FOR THE JOINT HEARING OF THE
SENATE AND HOUSE COMMITTEES
ON VETERANS' AFFAIRS**

**LEGISLATIVE PRIORITIES FOR
THE FIRST SESSION
OF THE 116TH CONGRESS**

February 27, 2019



**AIR FORCE SERGEANTS ASSOCIATION
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**** A participating organization in The Military Coalition ***

CURRICULUM VITAE

Keith A. Reed is the Executive Director of the Air Force Sergeants Association. He oversees the daily operations, advocacy efforts, outreach and support on behalf of the Association's 100,000 dues-paying members world-wide. Mr. Reed is a 20-year Air Force Veteran and retired Master Sergeant. He joined the Air Force as an Administrator/Information Manager and spent most of his career in staff support and military protocol and eventually served this Nation as a United States Air Force First Sergeant, culminating his career at Maxwell Air Force Base as the 42nd Mission Support Squadron First Sergeant responsible for overseeing the health and welfare of more than 400 enlisted members. Mr. Reed brings over 20 years of AFSA-experience that positively connects leadership at all levels along with the veteran and military audience to ensure AFSA continues to advocate on behalf of the Total Forces, their families and survivors.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Air Force Sergeants Association (AFSA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts. All the Association's activities and services are accomplished completely free of any federal funding.

* * * * *

Chairmen Isakson and Chairmen Takano, on behalf of the Air Force Sergeants Association (AFSA), I thank you for this opportunity to offer the views of our members on legislative priorities for the first session of the 116th Congress, specifically the decisions that have to be made as we move toward Fiscal Year 2020.

AFSA is a 100,000 member-strong, federally chartered, worldwide Veterans Service Organization (VSO) and Military Service Organization representing the quality-of-life interests of current and past enlisted Airmen as well as their families. We are in a unique position to have a good understanding of the views of enlisted servicemembers as approximately half of our membership are currently wearing a military uniform, and half are retirees or veterans. Our members are well-aware of issues that impact veterans as they are proud to hold that status while in uniform—and understand they will be impacted by your decisions today and in the future. We have 132 chapters, many of which are located at almost every Air Force base around the world, as well as a variety of retiree/Veteran chapters. As such, we have the pulse of our members and regularly receive feedback on a variety of important issues. The matters addressed by these Committees are closely watched and appreciated by our members: those who join the military and put their lives at risk each day to serve the national interests of our people.

This statement is intended to look forward, not to detail the shortfalls of the Department of Veterans Affairs or the actual and potential collateral damage to veterans caused by

misdirected priorities. All the members of these Committees are all-too aware of those failings. Nor do we intend to reiterate the strong communication our members have provided to us and to their elected officials as these issues have transpired. In this testimony, we have also tried to avoid the restatement of data and statistics with which these Committees are already familiar. However, in looking forward, in this statement we will point toward key issues as we see them, and a few recommendations of our Association about the need to alter current paradigms that we hope will be considered in your important deliberations on how this very large department should best operate in the future.

We are extremely proud to represent enlisted veterans and their families. About 90 percent of this nation's military veterans are enlisted personnel. In making its policy and funding decisions, we contend this Congress and the VA should factor in the unique circumstances of enlisted veterans (some of which we will point out in this statement).

For more than 58 years, the Air Force Sergeants Association has proudly represented active duty, guard, reserve, retired, and Veteran Enlisted Air Force members and their families. Your continuing effort toward improving the quality of their lives has made a real difference, and our members are grateful. The content of this statement reflects the views of our members as they have communicated them to us. As always, we are prepared to present more details and to discuss these issues with your staffs.

* * * * *

The Independent Budget (IB). At the time this statement was prepared, the president had not yet released his proposed FY 2020 budget for VA, so we are unable to comment on those figures at this time. However, as in past years, the AFSA concurs with funding levels recommended by "The Independent Budget for the Department of Veterans Affairs (VA), a document jointly authored by the VFW, DAV, and PVA. For FY 2020, The Independent Budget recommends approximately \$88.1 billion in total medical care funding and approximately \$90.8 billion for FY 2021. The Independent Budget also recommends approximately \$3.04 billion for all VBA operations, roughly \$5.7 billion for Departmental Admin. and Misc. Programs, and nearly \$2 billion for the department's construction projects and programs in the coming fiscal year. We value the hard work and commitment to accuracy that goes in to preparing the IB; your continued willingness to use it as a guide during your budget deliberations is greatly appreciated.

VA HEALTH CARE MATTERS

VA MISSION Act. The “*VA MISSION Act of 2018*” will fundamentally transform elements of VA’s health care system and like many other VSO’s/MSO’s, we are preparing for its launch later this year. Due to the complexity associated with the new VA health care system, the delay is needed to make certain that new regulations are prepared, and all new system changes developed and tested so the department can make certain they are ready to go when the time comes. We would rather have them delay and be ready, than have them pretend they are ready and through a catastrophic failure prove they are not.

On January 30th VA proposed new standards for access to care which when finalized would go into effect later this year. Their eligibility criteria and final standards were based on VA’s analysis of all the best practices both in government and in the private sector and tailored to the needs of our Veteran patients. As you are probably aware, their access standards will be based on average drive time and appointment wait times.

- For primary care, mental health, and non-institutional extended care services, VA is proposing a 30-minute average drive time standard;
- For specialty care, VA is proposing a 60-minute average drive time standard; and
- VA is proposing appointment wait-time standards of 20 days for primary care, mental health care, and non-institutional extended care services, and 28 days for specialty care from the date of request with certain exceptions.

Eligible veterans who cannot access care within those standards would be able to choose between eligible community providers and care at a VA medical facility. For urgent care, the VA proposes a veteran could receive care at any provider in the community care network but may be charged a copay for that service

As a rule, we support basing eligibility on wait times and driving distance on time rather than straight-line mileage. We cannot support charging a Veteran for care of an illness or injury that is service connected—*which at first glance appears could happen under the proposed rules for urgent care*. We are still looking them over and look forward to working with the VA as they finalize access standards for the new program. At this point there is simply not enough information to fully gauge how they may affect veterans who choose to rely on VA for the care or for that matter, are they realistic and feasible. In truth, we may not know how effective they are until the program launches.

Finally, it is important that the department receives the necessary resources to fully implement the MISSION Act. This includes the necessary funding to bolster IT infrastructure, expand telehealth access and recruit top notch doctor’s nurses and other healthcare professionals to administer various programs. Care in the community is more

expensive than at VA facilities, and no funds should be diverted from existing VA programs or modernization plans just to make the community care piece work. It should be fully funded, without jeopardizing the health or safety of veterans receiving their care directly from VA.

Care of Women Veterans. Women's representation within the Armed Forces (16 percent), Military Reserves, and National Guard (20 percent each) is growing, composing an increasingly large share of the military and veterans' populations. Women veterans now comprise about 10 percent of the total veteran population, and more than 7 percent of the veterans using VA health care services. In the next decade, women are projected to make up more than 10 percent of VA's users. Therefore, the system must be prepared to address not only the most frequent medical conditions women face, but also the unique and evolving issues associated with women in combat. Even though VA has made tremendous progress to improve services for women, they still lack consistent access to a full range of gender-sensitive healthcare benefits and services. Female veterans require and should be able to receive the full continuum of health care, including comprehensive primary care (care for acute and chronic illness and gender-specific care), specialty care, mental health care, disease prevention and screening, emergency care, and women's health specialty care (e.g., advanced breast and gynecological care, maternity care, and some infertility treatments). The latter being one area of care where the department is lacking. There also needs to be emphasis on programs for women veterans with special needs, including rural, homebound, and aging veterans as well as women who have lost limbs.

Finally, the lack of privacy at some locations is an issue we have heard of. Each major VA facility should have dedicated areas where women veterans can go to receive their treatment. VA has made good progress in women's healthcare but there needs to be a concerted effort to grow and develop these programs if the department is expected to keep up with the growing demand. For that reason, we have endorsed S. 514, the *Deborah Sampson Act* because it seeks to eliminate access barriers for women at VA and create health care options that meet their unique, gender-specific needs.

Military Sexual Trauma. Military sexual assaults—both reported and unreported—are a travesty impacting those who serve this nation. The victims include both male and female servicemembers. *We urge these Committees to ensure all VA medical facilities include professional staffing to screen, diagnose, and treat veterans who have been such victims. Ensure funding is provided within the VA system so requisite training is also provided. Finally, we request these Committees continue to ensure the support, training, and resources are available to ensure fair adjudication of disability claims relative to military sexual assault.*

Suicide Prevention and Mental Health Services. Suicide rates among veterans remains unacceptably high. The AFSA has long believed that VA needs to develop and sustain a comprehensive behavioral health system that enables the department to treat a plethora of

mental health conditions to combat the rising rates of suicides. It is unclear in 2018 if they did that, and we would encourage these committees to evaluate the current effectiveness of VA suicide prevention programs in the coming months.

Through regular interaction with our members, we know most veterans don't know what kind of mental health services VA offers. Respectfully, we were greatly disturbed when a Government Accountability Office study (GAO-19-66) released in November 2018 revealed that of \$6.2 million set aside for suicide prevention media outreach in fiscal 2018, only \$57,000 (less than 1 percent!) was used. Secretary Wilkie assured these committees that those funds won't go unspent again. The fact these monies were not spent as intended may be a sign of poor management or lack of concern and we hope you will step up oversight in the area of VA outreach.

Electronic Health Record (EHR). VA was the pioneer of the Electronic Health Record (EHR) with the development of Veterans Health Information Systems and Technology Architecture (VistA). However, after almost 40 years of use, VistA lacked the interoperability necessary to effectively serve veterans and according to many, was simply too costly to maintain. VA signed a contract with Cerner Corp. on May 17, 2018, to replace VistA with the new Cerner system, which is in development at the Department of Defense (DoD) as well. The modernized system will allow VA to have patient data shared seamlessly between VA and DoD.

We believe an EHR remains critical for continuity of health care, and VA claims processing. Therefore, VA must request, and Congress must provide, all the resources necessary to continue development of all of VA's Information Technology efforts until the new EHR system is not just implemented, but fully adopted and sustained.

Support the judicious use of VA-DoD sharing arrangements. The AFSA supports the judicious use of VA-DoD sharing arrangements involving network inclusion in the DoD health care program, especially when it includes consolidating physical examinations at the time of separation. It makes no sense to order a full physical exam on your retirement from the military and then within 30 days, the VA orders its own complete physical exam with most of the same exotic and expensive exams. The decision to end that duplication process represents a good, common-sense approach that should eliminate problems of inconsistency, save time, and take care of veterans in a timely manner, not to mention save critical funding dollars.

However, the AFSA recommends these Committees closely monitor the collaboration process to ensure these sharing projects improve access and quality of care for eligible beneficiaries. A word of caution, DoD beneficiary participation in VA facilities must never endanger the scope or availability of care for traditional VA patients, nor should any VA-DoD sharing arrangement jeopardize access and/or treatment of DoD health services beneficiaries. The VA and DoD each have a lengthy and comprehensive history of

agreeing to work on such projects, but follow-through is sometimes lacking. *We urge these Committees to encourage joint VA-DoD efforts, but ask you to exercise close oversight to ensure such arrangements are implemented properly.*

Support VA-Medicare Subvention. With a large percentage of veterans eligible for Medicare, VA-Medicare subvention is a very promising venture, and AFSA offers support for this effort. Under this plan, Medicare would reimburse the VA for care the VA provides to non-disabled Medicare-eligible veterans at VA medical facilities. This funding method would, no doubt, enhance elderly veterans' access to VA health care and enhance access for many veterans. *We urge these Committees to carefully study and consider supporting VA-Medicare Subvention.*

Wounded Warriors. Thousands of service members have been wounded in action over the past 14 years. Thousands of others have suffered service-connected illness and injuries in related support actions. As a Nation, we have no greater responsibility than to care for our warriors now suffering from the maladies of war. We are pleased with high levels of funding support for Wounded Warrior care and hope this trend never wanes. Continued emphasis and funding are needed for VA programs that address Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD), the two “signature injuries” of our two recent conflicts.

Expand VA Chiropractic Care. Public Law 108-170 and Public Law 107-135 are the two congressional directives that made it possible for some veterans to receive the chiropractic care they so desperately need at VA facilities. We understand increasing numbers of veterans are receiving care by chiropractic providers, but this service is extremely limited at many facilities and not available at others. It's vitally important that all our veterans have access to non-drug approaches to pain management like those offered by chiropractic physicians, particularly in light of the opioid epidemic that is gripping our country.

SUPPORTING VETERANS' CAREGIVERS

VA's Comprehensive Assistance for Family Caregivers Program. We strongly believe there should be no distinction in the sacrifices made by severely disabled veterans or their families, regardless of where or when they served. So, we can't thank these two committees enough for expanding VA's Comprehensive Assistance for Family Caregivers Program to veterans from other eras. The program currently applies only to those who joined the military on or after September 11, 2001. Soon those who were injured in the line of duty on or before May 7, 1975, would be eligible for the caregiver benefits and two years after that, those injured after May 7, 1975, but before September 11, 2001, would be covered. We remain hopeful that the program will expand even further in future years to include veterans suffering from catastrophic illnesses that are also service connected. And, as the number of veterans in this program increases, VA must request, and Congress must

provide enough funding for the caregiver program within the medical services' appropriations.

Ahead of the expansion effort however, the current program requires your attention. Last September, VA's Office of Inspector General (OIG), reported (#17-04003-222) the department has not adequately monitored its Caregiver Assistance Program, resulting in patient care access limitations and insufficient program discharge processes. And in December, at Congress' urging, VA imposed a ban on removing families from the program following news reports that catastrophically injured veterans were being unceremoniously dropped from it. The OIG recommended several changes including that VHA establish policies and implement procedures to improve Family Caregiver Program operations. That would seem enough to warrant a hearing on this subject to ensure compliance.

MILITARY-TO-VETERAN TRANSITION ASSISTANCE

Transition Assistance Program (TAP). As the members of these Committees know (and implemented), transition assistance training is now mandatory for those who leave military service. This is necessary to ensure the transition into society is as smooth as possible, and these veterans are aware of and understand the programs available to them. The goal is to allow them to capitalize on the unique training and work ethic that came with their military service. Transition assistance training rightfully includes employment, education, health care, how to obtain disability benefits, and available mental health services. The overall goal is to make them productive citizens. The curricula of these programs must be kept current and allow veterans to explore opportunities available to them. *We urge these Committees to fully support and work to fund these programs.* These programs should also steer those transitioning toward the ways they can use TAP resources in the future, after separation. Training provided to staff can make VA Centers the go-to places for veterans to seek such support.

Licensing and Credentialing. *Of importance to enlisted veterans, we want to emphasize the licensing and credentialing of veterans, allowing veterans to convert their military skills into civilian occupations.* It must be remembered that enlisted (noncommissioned) members are far more likely to have gotten training in and served in non-transferable skill fields.

Accordingly, Congress should ensure the Departments of Veterans Affairs and Defense work collaboratively to find ways to allow these military members to be successful and employable when they move into Veteran status. While they are still in service, DoD should afford these servicemembers opportunities to get properly credentialed and provide education so that these soon-to-be veterans understand the proper procedures/processes to make that happen.

The AFSA encourages Congress to look at any additional ways to expand civilian/state licensing and credentialing programs for service members in all possible occupational specialties. At a time when the DoD spends nearly \$2 billion each year to finance Veteran unemployment benefits, exposing servicemembers to relevant credentialing opportunities while in uniform creates better trained military professionals, and allows these highly-trained professionals to more easily find jobs after leaving the military.

CLAIMS ADJUDICATION PROCESS/APPEALS

New Appeals Process. The new appeals program launched on time last month, but it is too early to tell how well it is working. We appreciate the fact it gives the Veteran a greater say in how their claim is handled and confident it will help the Board of Veteran Appeals clear through thousands of pending claims. Perhaps our only concern is the 30-minute time limit that has been placed on the in-person hearings. These official inquiries were intended to provide veterans a non-confrontational environment to tell their side of the story. That can be challenging when you are under the gun of a time clock. Your continued emphasis to ensure that the implementation and utilization of the new appeals system goes smoothly is greatly appreciated.

ENVIRONMENTAL ISSUES

Burn Pits. We strongly recommend these Committees take another look at the use of burn pits and the ill effects they have had on military service members. For quite some time, the disposal of trash on military bases through open-air burn pits exposed service personnel deployed in Iraq, Afghanistan, and other locations in Southwest Asia to airborne particulate matter and other potential health hazards, which in turn raised concerns about acute and chronic health consequences in these individuals. Public Law 112-260, § 201 (enacted January 10, 2013) directed the Department of Veterans Affairs (VA) to establish and maintain a registry for service members who may have been exposed to toxic airborne chemicals and fumes generated by open burn pits. But a congressionally mandated report from the National Academies of Sciences, Engineering, and Medicine looking at this registry determined that additional means are necessary and should be developed to further evaluate the potential health effects resulting from toxic emissions on service members.

The AFSA supports the H.R. 1001, the Family Member Access to Burn Pits Registry Act of 2019 and H.R. 1005, the Burn Pits Veterans Revision Act of 2019, and similar legislation which seeks to create a "center of excellence" within the Department of Veterans Affairs to further "prevention, diagnosis, mitigation, treatment and rehabilitation of health conditions relating to exposure to burn pits".

Blue Water Navy. Finally, on behalf of AFSA members who served in the sea services, AFSA supports the "Blue Water Navy Vietnam Veterans Act" and any other legislative

effort which would clarify a presumption for filing disability claims with VA for ailments associated with exposure to Agent Orange herbicide during the Vietnam War. *We urge these committees to support this legislation and work toward its enactment.*

EDUCATION PROGRAMS

Housing Stipend Glitch. Last year, a software issue prevented the VA from paying veterans housing allowances and other benefits provided by the GI Bill. Last we heard, the department was working the issue and it is imperative that these veterans receive every penny that they are owed.

Protecting Post-9/11 GI Bill Users from Deceptive Practices. AFSA remains concerned about inadequate quality standards and oversight of the GI Bill. Too many veterans and too much GI Bill money is being wasted on extremely low-quality schools that are under law enforcement action for defrauding students and the government. We urge the Committees to consider minimum quality standards for GI Bill. Second, we encourage the Committees to ensure that colleges spend veterans' benefits educating the veteran. Some bad actor colleges spend veterans' hard-earned GI Bill on profit set-asides, luxury cars, stock options, and TV ads. That's not what veterans fought for. Third, we urge the Committees to strengthen student protections at VA by aligning protections with the Departments of Defense and Education. Specifically:

(a) While the Education Department has a mandatory Program Participation Agreement governing schools that want Title IV funds, and the Defense Department has a mandatory Memorandum of Understanding for schools that want to participate in DOD voluntary education programs, VA has only a voluntary "Principles of Excellence." This leads VA to feel helpless to stop bad actor schools. We urge the Committees to consider codifying and strengthening the Principles of Excellence.

(b) VA should similarly align with the Defense and Education Departments on the disbursement and claw backs of federal funds. While the Education Department disburses funds to colleges on a pro-rated basis during the semester, and while DOD disburses funds only upon the servicemember's successful completion of the semester, VA sends the entire term of GI Bill after a veteran sits for one day of class. This incentivizes bad actor colleges to lie to veterans about the college to get them to sit for just one day, and then, when the veteran realizes the college is lousy and drops out, bad actor colleges keep the veteran's GI Bill. While the Education Department recoups any overpayments from the schools directly, and while DOD suffers no overpayments because it pays only at the end of a term, VA recoups overpayments directly from the veteran, withholding veterans' disability payments and putting a lien on veterans' tax refunds, even though the school received the money. The US Government Accountability Office wrote a report criticizing this practice and noting that it caused more than \$400 million in overpayments in 2014 alone. Veterans

should not be on the hook for money that was sent to a school.

(c) Finally, program approval and compliance monitoring for VA by the State Approving Agencies needs to be strengthened. Too many low-quality fraudulent programs are being approved for GI Bill and the compliance monitoring is inadequate. Program approval and compliance are much stricter at both the Education and Defense Departments.

Education Benefits for Survivors and Dependents. VA's Survivors & Dependents Assistance (DEA) Program (Chapter 35) provides education and training opportunities to the spouses and eligible children of certain veterans. Whereas the benefit rates for most VA educational programs have increased in recent years, the payout rates for the DEA program have not. As a result, the value of this benefit continues to erode as college costs continue to climb. *Accordingly, we urge Congress to take action now to boost DEA benefit rates to closely match the current cost of a four-year public university.*

HOMELESS VETERANS

Prevent Veteran Homelessness. On an average night in 2018, an estimated 37,878 veterans were experiencing homelessness. That's a reduction of nearly 2,200 from the year before according to U.S. Department of Housing and Urban Development (HUD) figures. Significant progress has been made in housing our nation's homeless veterans thanks in part to rapid re-housing through VA's Supportive Services for Veteran Families (SSVF) program and the HUD-Veterans Affairs Supportive Housing program. Numerous other programs contributed to the smaller number as well, including, outreach, employment, transitional housing, and substance use treatment.

The most effective programs for homeless and at-risk veterans appear to be community-based, nonprofit, "Veterans helping Veterans" groups and greater focus needs to be placed on expanding these opportunities. Veterans who participate in these types of collaborative programs are afforded more services and have higher chances of becoming tax-paying, productive citizens again.

Protect VA Disability Compensation during Divorce Settlements. Despite being clearly stated in law, veterans' disability compensation has become an easy target for former spouses and lawyers seeking money. Courts have, in some cases, allowed this to transpire despite the fact the law states that veterans' benefits "shall not be liable to attachment, levy, or seizure by or under any legal or equitable process, whatever, either before or after receipt by the beneficiary." Once a rare occurrence, we hear this is happening with increasing frequency. *Now is the time to consider enactment of a specific prohibition to specifically preclude the award of VA disability dollars to former spouses or third parties during civil proceedings.*

SUPPORT OF SURVIVORS

SBP/DIC Offset. The last Congress passed legislation to make the \$310-a-month Special Survivor Indemnity Allowance (SSIA) permanent and begin adjusting it for inflation each year. AFSA did not agree with this approach because it penalized all TRICARE beneficiaries and forced survivors to pay for their own earned benefit. We appreciate the fact that something was done to extend this vital income for survivors, but it's important to remember that SSIA was created by Congress because they agreed that it is wrong to deny the surviving spouse the full amount of compensation. So, I repeat the challenge made by my predecessors, that *the members of these Committees to work with your colleagues on the House and Senate Armed Services Committees to end the SBP-DIC offset permanently.* We endorse the view that surviving spouses with military Survivor Benefit Plan (SBP) annuities should be able to concurrently receive earned SBP benefits and dependency and indemnity compensation (DIC) payments related to their sponsor's service-connected death. In multiple Congresses, a majority of House and Senate members acknowledged they share this view, but a solution continues to elude us. Even in a budget-constrained environment, fair treatment for survivors of veterans who gave their lives for their country must be considered a funding priority. We understand the actual fix falls within the jurisdiction of the Armed Services Committees, however, the survivors of these veterans who are entitled to both DIC and SBP deserve all our support.

Dependency and Indemnity Compensation (DIC) Value Equity. DIC, which is paid to survivors of those who paid the ultimate sacrifice, is set at a flat rate for all. *AFSA believes DIC rates should be established at 55 percent of the compensation paid to 100 percent service-disabled veterans, placing them on equal footing with the survivors of disabled civil service employees.*

Remarriage Provision. With current military deployments and increasing casualties, it is imperative we plan to properly take care of those who may be left behind if a military member makes the ultimate sacrifice. We commend these Committees for previous legislation, which allowed retention of DIC, burial entitlements, and VA home loan eligibility for surviving spouses who remarry after age 57. *However, we strongly recommend the age-57 DIC remarriage provision be reduced to age 55, again placing them on equal footing with their civil service counterparts.*

Mandatory Arbitration. Like many of our Coalition partners, AFSA opposes mandatory arbitration agreements in financial and employment contracts and encourages the passage of legislation to make them unenforceable in cases arising under the Servicemember Civil Relief Act (SCRA) and the Uniformed Services Employment and Reemployment Rights Act (USERRA). These mandatory arbitration clauses limit servicemembers ability to seek redress in court and prevent transparency in the legal process overall. We support legislation that would make mandatory arbitration agreements in financial and employment contracts unenforceable under SCRA and USERRA.

CONCLUSION

Chairman Isakson, Chairman Takano, and Committee members, I want to thank you again for this opportunity to express the views of our members on these important issues as you consider the FY 2020 Budget. We realize those charged as caretakers of the taxpayers' money must budget wisely and make decisions based on many factors. As tax dollars must be prioritized, the degree of difficulty deciding what can be addressed, and what cannot, grows significantly. However, like you, we feel it is entirely appropriate this nation provide quality health care and appropriate benefit programs to properly recognize the devotion, sacrifice, and service of our nation's veterans.

We sincerely believe the work of your Committees is among the most important that will take place on the Hill this year. These two Committees have historically illustrated the value of non-political cooperation with the full focus of your efforts on the well-being of those who have served and are serving this nation. On behalf of all AFSA members, we appreciate your efforts, and as always, we stand ready to support you in matters of mutual concern.

(End)

Association of the United States Navy

Written Testimony in Support of 2019 Legislative Agenda

Submitted to the United States
Senate Veterans Affairs Committee
and House Veterans Affairs Committee



Rear Admiral Christopher Cole, USN, Retired

Chief Executive Officer

March 5, 2019

Introduction

Distinguished Committee Chairmen Senator Johnny Isakson and Congressman Mark Takano, and Ranking Members Senator John Tester and Congressman Phil Roe and other members of the Committees, thank you for the opportunity to present the 2019 Legislative Agenda for the Association of the United States Navy.

About Association of the United States Navy

The Association of the United States Navy (AUSN) is an IRC 501[c][19] organization based in Alexandria, Virginia, that works for the benefit of the U.S. Navy Sailors and Veterans. Through legislation and education, AUSN works to advance benefits for those who are serving or have served in the U.S. Navy. AUSN champions legislation on the state and federal levels and engages in targeted issues to support our men and women of the U.S. Navy.

Opening:

On behalf of the Active Duty, Veteran and civilian membership, friends and supporters of the Association of the United States Navy, I would like to thank the Committees for the stewardship and oversight you have provided for all those who have answered the call of duty.

It is an exciting time at AUSN – we are innovating, partnering and aligning ourselves to meet the needs of modern-day Sailors and their families, in parallel with our dedication to our Veterans who have given so much. We are breaking the mold that once formed so many sea-service veteran service organizations (VSOs) as AUSN represents the interests of the entire United States Navy. As promised in last year's testimony, we have forged a strong alliance with the Navy Safe Harbor Foundation, which ensures our Navy's wounded warriors and their families are cared for and supported the Navy way.

A lot has happened since we testified last year. As you know, the Blue Water Navy Vietnam Veterans Act was not enacted, despite having overwhelming bipartisan support in both the House and the Senate. That came as a tremendous disappointment, as for yet another year “Blue Water” Navy Vietnam Veterans who were exposed to Agent Orange will have to battle their illnesses on their own for at least another year as Congress once again pushes this bill forward. We thank you for your support for this bill, and urge your continued vigilance in ensuring its passage in 2019.

Despite this disappointment, there have been positive developments in 2019. Thanks to your efforts, Veterans receiving disability pay and military retirees will see a 2.8 percent cost-of-living increase for 2019, the largest increase in years. We urge the Committees to continue to push for COLA increases on an annual basis to ensure our Veterans are taken care of.

But there are many issues that our Shipmates continue to face, issues that we hope your Committees will work to address this year. Issues such as Veterans' homelessness, suicide, and simply not getting the care they are entitled to through the Department of Veterans Affairs remain key concerns for AUSN.

Toxic exposure continues to be a major ongoing concern. Beyond Blue Water Navy, there is also Burn Pits and PFAS. And there will be other cases in the future. AUSN urges the Department of Defense to improve record-keeping and Congress to establish funding for research centers so that we can get out ahead of toxic exposure issues. That way, Veterans aren't having to go to the VA

or Congress decades after the fact, only to be rebuffed because of poor data and record-keeping.

AUSN is also concerned about a continued problem with predatory educational institutions, which hook Veterans with promises of an education that will help them establish a promising career after service, only to provide a lackluster education and a massive bill. We urge Congress to increase its oversight of these for-profit companies and ensure our Veterans have access to quality, affordable education.

AUSN has been encouraged by the strong leadership your Committees have taken on Navy personnel issues. Everyone here is clearly concerned about taking care of our Sailors, both those serving and those retired, and for that we thank you. But this work requires constant vigilance, and 2019 will be no different.

The reality is that, despite many improvements, our Shipmates still struggle at times to obtain health-care services or they encounter uncertainty in their treatment options. We need new ideas to end uncertainty and turbulence for Sailors, and AUSN supports the modernization of the Department of Veterans Affairs and will do anything we can to assist in that process.

Many of our Veterans are well cared for, but many continue to fall through the cracks. That's why we exist: to ensure that all Sailors and Veterans, whether they served decades ago or are still in uniform, have a system in place that will

take care of them as they have taken care of this country with their service. We are willing to step in to support, but we cannot do it all, and so we urge the Committees to continue to work toward providing support to all Sailors and Veterans.

AUSN believes that to best care for those who have borne the scars of our nation's battles, the medical care priorities of our Veterans must be aligned as:

- 1) Continuity of care between the Departments of Defense (DoD) and Veterans Affairs (VA),
- 2) Consistent quality of care, and,
- 3) Sustained certainty in funding to provide timely, high-quality health care for our Veterans.

Currently, there are two distinctly different medical systems dedicated to dealing with our service members and Veterans – the DoD and the VA. While each medical system services a different population – either those who currently wear or who have previously worn the uniform of our nation's Armed Forces – the problem lies in the fact that each system is structured to treat its patients in different ways. The DoD medical system treats Active Duty service members, generally healthy men and women answering the call of duty to our nation. The VA medical system is dedicated to a wide range of Veterans, varying in age and with complex medical issues that may not have begun to impact them until long

after they left the service. Even more complex is the care required for the children of our Veterans whose afflictions originate with their parent's service.

AUSN believes that the DoD and VA medical systems should not be concerned with whether the patient is a Sailor deployed on a ship, submarine or ashore, or if the patient is a Veteran trying to receive assistance for a disability that he or she suffered while on active duty. Our men and women should be receiving the same treatment and the same quality care from the day they enter the military and swear their oath to support and defend the Constitution of the United States of America until the day they die.

Our Navy's Shipmates in Need:

AUSN's membership is passionate about providing comfort and care to our Shipmates and Veterans whose service has resulted in hardship and scars, both seen and unseen. AUSN has embarked on an innovative project designed to dramatically augment how our country cares for our wounded Shipmates that focuses on providing the resources that our government does not provide. AUSN's partnership with the Navy Safe Harbor Foundation throws open opportunities to assist those suffering from illness, injury, or battle wounds to engage in new approaches to recovery. Right now, the Navy Wounded Warrior Safe Harbor Program does its mightiest, herculean in fact, to address the needs of these Shipmates. But, like many Federal programs, it is limited by resources. The reality is that this program can only bring so much care to these Sailors. AUSN – in

partnership with the Navy Safe Harbor Foundation – can provide financial, emotional and informational assistance for a healthy transition from military life.

Continuity of Care:

Our nation has a long history of caring for our servicemembers when they go into harm's way, and to continue medical treatment when required. For many years, organizations have called for overhauling the VA system due to lack of continuity of care. AUSN believes that a solution to continuity may be to incorporate the successful medical care aspects of the DoD medical system with that of the VA.

AUSN stands with your Committees to ensure those who suffer from Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) receive world-class medical care. While both the DoD and VA medical systems treat PTSD and TBI, they have their own distinct medical care processes. A Sailor injured in combat while serving in Iraq, Afghanistan, or elsewhere may be medically evacuated back to the United States to be treated at Walter Reed Medical Center. That Sailor may receive care and treatment not currently available for their Shipmates with the same injuries being treated at VA facilities. Conversely, if a service member is being provided specific health-care treatment while on active duty and is then transferred to receive health care at a VA facility, the current dual system may not recognize the medicine or health-care treatment they have been receiving. Some Veterans have been required to restart treatment, from the

beginning, in the VA system, leading to significant medical condition regression compared with the progress that had been made while they received DoD medical care on active duty. Additionally, when a service member or Veteran is transitioning from one facility to another, the only thing that should change is their doctor, not the treatment or quality of care received.

Members of these honorable Committees, a successful way to ensure continuity of care is expediting the full digitization of medical records. At this time last year, we offered the example that almost every county in the country has digitized their patients' medical records. It is intuitively obvious to medical service providers that expedited continuity of care is largely enhanced with access to a patient's digitized medical records. Is it possible for the VA and DoD to have one common digitized medical records program? AUSN says yes, it is possible. We suggest that to improve alignment, expedite continuity of care and fluidity between the DoD and VA medical systems, digitizing VA medical records should be a top priority.

Quality of Care:

The nation's quality of medical care for our Veterans runs the complete gamut. Some private institutions or organizations provide high-end medical care for their patients, sometimes at a significant cost. Several recommendations have circulated with respect to privatizing the VA Department to provide Veterans the choice to seek and keep their own doctors.

In some current DoD medical systems, with no military treatment facilities nearby, it is a common practice to provide service members the ability to choose their own doctors. It is then the responsibility of the service member to ensure that medical documents are provided to their Command, so they can be filed in the military medical record.

Veterans should not only have the right to choose, but also should receive the best treatment and quality of care in the facility where medicine excels – be it a DoD or VA facility – if it is the best fit for the Veteran.

AUSN recommends that by aligning and combining programs, the U.S. government could save money and provide additional benefits for our service members and Veterans. Uniting the best of these two medical systems into a cohesive unit would allow for quality and continuity of care among our service members when they transition from DoD medicine to VA medicine.

It is important that the VA focus on what it does best: caring for service-related injuries. The VA should align its policies and work more closely with DoD medicine, along with medical research institutes, to strive to provide the most modern, transparent and best possible care for our Veterans.

Helping Lost Shipmates:

A goal moving forward for AUSN members is to activate their state and local resources with the goal of bringing relief to our homeless Veterans. As you

know, homelessness is a complex issue and our Navy Veterans reflect a microcosm of our society. Our efforts focus on transitioning the Sailor to civilian life and providing avenues to employability, training and socialization.

Proper Funding:

AUSN believes that the key to improving Veteran care is providing consistent, sustained funding. The biggest issue facing the implementation of a modernized VA medical care program is figuring out the best way to pay for it.

One way is through community partnerships with other health-care providers. Veterans often find themselves using the VA for everything, because, to them, they feel connected to the people they encounter while at the VA. One possibility for ensuring that Veterans are using the VA for only service-related injuries is to provide insurance for Veterans who did not retire from service and were honorably or medically discharged. Providing Veterans this option for insurance would allow the VA to use the revenue to fund other medical care benefits that are urgently needed for our Veterans. When Veterans require medical care from a doctor, because of PTSD, TBI, or from an injury they received while on active duty, the VA may or may not be the best facility to care for them. If these Veterans have medical conditions outside of military-related injuries, they should be able to go to any health-care center provided through the Tricare system.

DoD medicine has been constant, consistent, and adaptive when it comes to caring for our Sailors, and AUSN suggests there should be no difference when it comes to the continuity and quality of care of our Veterans.

The funding for the DoD and VA for Veteran medical care must be sustained and consistent. At the time of a service-related injury or an exposure to toxins, for example, a Veteran may be unaware of current or long-term medical dangers. The Congress and our nation should hold the bottom line that Veterans should NOT be denied medical care for deserved and required treatment of service-related injuries or exposure to toxins.

Closing:

In closing, let me say this: when it comes to our Sailors and Veterans' health, we must not take our eye off the ball. The suicide rate for Veterans ages 18-34 surged by around 10% between 2015 and 2016, according to the latest VA statistics. Toxic exposure continues to claim Veteran lives every year, sometimes decades after the initial exposure. And many others simply struggle to get the care they need through an oftentimes byzantine health care system between the DoD and the VA.

Real lives are at stake here. We must not hem and haw, we must not drag our feet, we must not kick the can down the road when it comes to the health of our Sailors and Veterans. Delaying necessary care by a year to wrangle over records and data means actual lives will be lost. The silent scourge of inaction has fatal

consequences for those who have fought on the front lines for the United States of America.

I leave you with the story of Dennis, a Veteran we helped through the Navy Safe Harbor Foundation who has been battling brain cancer for years. Despite having tremendous skills that would make him a valuable asset in the business world, he faced having his electricity shut off because of being too sick to work – all while having a family to support. One can only imagine how difficult that must be for a Sailor who served his country with honor and distinction.

The Veteran community is filled with stories like these. It's a major reason why AUSN exists. And it's a stark reminder that what we do here has a real effect on the lives of American heroes.

Thank you for your continued bipartisan support of our Veterans, and I stand by for any questions the Committees may have.



REAR ADMIRAL CHRISTOPHER W. COLE, USN (RET)
Chief Executive Officer

Using the breadth of experience gained from his career in the Navy and private sector, Rear Admiral Cole comes to AUSN through his service as President of the Navy Safe Harbor Foundation. RADM Cole's chief platform while serving as National Executive Director is to bring about an alignment of our organization's modernization plan with the needs of the US Navy in three areas; 1) professional development of Sailors throughout their career; 2) providing opportunity for Sailors transitioning, and; 3) addressing the needs of our struggling and wounded Shipmates and offering relief and support.

During his military career as an aviator, Rear Admiral Cole served in various flying and staff positions, ultimately commanding two aircraft squadrons and two amphibious ships. He graduated from the Naval War College, was a member of the Secretary of Defense Strategic Study Group and attended the John F. Kennedy School of Government at Harvard University.

As a Flag Officer, Rear Admiral Cole served as the Commander, U.S. Naval Forces Korea in Seoul, Republic of Korea; Commander, Navy Region Mid-Atlantic in Norfolk, Virginia; and Director, Ashore Readiness Division (N46) in the Office of the Chief of Naval Operations in Washington, D.C.

Upon retirement from active service in January 2004 and prior to joining AUSN Rear Admiral Cole was a consultant to the Defense Industry in national security, energy strategy, environmental protection, BRAC, military construction, and installation management. In addition to his AUSN work he serves as President of the Navy Safe Harbor Foundation and is Chairman of the Board of Directors of Military Bowl Foundation.



Non Commissioned Officers Association of the United States of America
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STATEMENT OF

**VINCENT W. PATTON III, Ed.D.
PRESIDENT AND NATIONAL COMMANDER**

**NON COMMISSIONED OFFICERS ASSOCIATION
OF THE
UNITED STATES OF AMERICA**

BEFORE THE

**JOINT HEARING OF
THE COMMITTEES ON VETERANS AFFAIRS**

UNITED STATES SENATE

AND

UNITED STATES HOUSE OF REPRESENTATIVES

Second Session, 116th Congress

Monday, March 11, 2019

Chairman Isakson, Chairman Takano, Ranking Members Senator Tester and Congressman Roe, Members of the Committees on Veterans Affairs, I am Vince Patton, President and National Commander of the Non Commissioned Officers Association of the United States of America (NCOA). NCOA appreciates this opportunity to present formally the Association's legislative concerns and priorities for the remainder of the 116th Congress.

The 116th Congress Assembled

I am here today to urge you to continue your commitment to our nation's Armed Services. A commitment to the men and women who have committed their lives to fight for our nations protection and safety.

I do not have to tell any of you that we face increasing international threats, economic constraints, and internal management challenges. We have seen the "war" against terror continue to challenge our determination – much like the tides it will continue to ebb and flow – with the evolution of ISIS and increased barbaric attacks against civilians across the globe. We have seen our deficit and budget challenges remain as our economy's performance continues to vex agency budgets. The Department of Veterans Affairs has experienced leadership and oversight challenges as they continue striving to take care of our deserving veterans.

It is in this context that you face extremely difficult decisions. The demands on our military personnel and their families will not decrease. I believe over the next few years; we will see a significant increase in our engagements. For these reasons, your committee will be faced with even more challenging decisions.

There is a nexus between how a nation takes care of its military personnel and veterans in relation to the future of military recruiting, military retention, readiness and capabilities in an all-volunteer force.

Our Soldiers, Marines, Sailors, Airmen and Coast Guardsmen commit their lives, families, and future to our country. They trust that you, as their elected officials, are constantly working on their behalf, taking care of them and their families in the event of their ultimate sacrifice, their disability, or their incapacitation. We must never waiver or fall back on that commitment.

Our Nation has an obligation to all service members and veterans to provide the best in medical and mental health care, research, and development of health treatment modalities, for as long as it's needed throughout their lives.

The United States has endured repeated attempts to terrorize us with both homegrown and transplanted terrorists. These continued challenges for both the DOD and VA will not be solved easily with a growing population of veterans. Budget shortfalls have created significant workload demands upon the Department of Veterans Affairs. Included will be significant increases for health care services (physical and mental health), disability claims, educational benefits, and entitlement programs administered by VA.

NCOA recognizes that the Committees have always been responsive and supportive of veteran needs in a nonpartisan spirit. The two Committees have been thorough in their assessment of past budgets, recognizing the inadequacies facing our veterans and thus acted to add critically needed program resources. VA's ability to continue fulfilling America's promises in the future will demand that an adequate budget is preserved and expanded as necessary to honor the institutional commitments made to America's veterans and their survivors.

The Oath is taken every day... year after year, NCOA recognizing all who serve in Congress or Uniformed swear an Oath of Office, Enlistment, or Commissioning in which the following affirmation is a sacred promise:

“...to support and defend the Constitution of the United States of America.”

NCOA remains cognizant, as you must also, that for military enlistment or commissioning the significance of those words to bear the possibility of extreme sacrifice and even death. The unquestioned belief of all who serve is that they will have the finest war fighting equipment, support services, healthcare, and ALL necessary institutional support while on Active Duty. They further believe that the Nation's institutional promises hold true. These promises include:

- quality and timely veteran health care when needed for the rest of the lives of America's veterans as a result of their military service,
- adequate benefits and entitlements to achieve a quality life,
- should they fall in the line of duty, the institutional commitment of this grateful Nation to care for their survivors.

The reality of a national deficit nearing twenty trillion dollars does impact all citizens including military members, veterans, and their family members. There is a real concern across the Nation relative to the resolution of the national fiscal deficit. Many military members, disabled veterans, and veterans feel that they will become disenfranchised from the healthcare programs, entitlements, and promised benefits as a result of being forced to bear the brunt of cost savings plans. Simply stated:

“Don't balance our country's budget on the backs of veterans and their survivors!”

NCOA believes for far too long some significant veteran issues have been neglected or negatively impacted as the result of budget implications. We propose examples of veteran issues that budget implications continue to neglect the Nation's “care for those who have borne the battle, their widows, and orphaned children.” Here are two examples:

- America's disabled veterans remember the objectives stated by President Obama at the start of the 111th Congress to allow Chapter 31, ALL disabled retired veterans concurrent receipt of their VA Disability Compensation and limited military retired pay. This remains not authorized by Congress.

- Likewise, promises to end the Widow's Tax and allow receipt of their VA Dependency and Indemnity Compensation (DIC) and concurrent receipt of their full military Survivor Benefit Program (SBP) annuity. Again, this remains not authorized by Congress.

NCOA will continue efforts to seek legislative entitlement of these issues and will not agree with any fiscal excuse for limitations that seek to dampen such benefits as these two concurrent receipt programs mentioned.

NCOA Legislative Goals for 2018

The primary focus of these goals is veterans' benefits authorized under Title 38 of the U.S. Code.

PRINCIPLES FOR VETERANS' HEALTH CARE AND BENEFITS

- Promote public and political recognition that veterans' benefits are earned through service and sacrifice in defense of the Nation and are qualitatively different from those normally described as "entitlement" or "social welfare" programs.
- Oppose deficit-driven or political decisions that would privatize the Department of Veterans Affairs (VA) health system or lump earned veterans' benefits with unrelated federal or civilian benefit programs.
- Oppose proposals that would eliminate or diminish veteran benefits to overcome national economic woes.

HEALTH CARE

Health Care System Reform. Support and invest in modernizing VHA technology, financial, infrastructure, electronic health records, and human resource systems, including reforming VA Community Care and Choice Programs. Establish robust leadership and management plans to meet transformational goals and evolving veteran and health system requirements. Critical elements to VHA reform should include:

- Overall health care coordination and navigation support for veterans.
- Investment in foundational and special-emphasis resources and specialty care services paramount to VA such as spinal cord injury, blind rehabilitation, mental health, prosthetics, and similar foundational services.
- Delivery of core mission functions such as clinical, education, research, and national emergency response to advance the health and well-being of veterans and population health.
- High-performing, high quality, integrated health care network, combining the best of VHA and the best of private sector community-based services.
- Highest priority in access to health care given to service-connected and low-income veterans.

VHA Health Care Workforce. Continue to pursue workforce improvements to VA health system by:

- Recruiting and retaining health care professionals, especially in high shortage areas

such as physicians, physician assistants, mental health providers, and nurses from other government and civilian sectors.

- Implementing independent practice authority for advance practice nurses (APRNs).
- Growing the existing MOU between VHA and Department of Health and Human Services from 30 to over 100 billets for members of the U.S. Public Health Service (USPHS) to serve in clinical and non-clinical roles.
- Establishing an MOU between VHA and USPHS to create and fund 10 slots per year at Uniformed Services University of the Health Sciences for medical students who agree to join USPHS and then serve in VHA clinics and hospitals to repay the government for their medical education.

Traumatic Injuries and Suicide Prevention. Implement and sustain an integrated, multidisciplinary, comprehensive behavioral health system to address the rising rates of veterans suffering from traumatic injuries such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and military sexual trauma (MST).

Specifically:

- Invest in programs and research to identify at-risk populations, expand evidence-based treatment, and improve delivery of care and rehabilitative and preventive services.
- Monitor the VA Suicide Prevention Office efforts to increase behavioral health staff, resources, and crisis line capacity, ensuring outreach efforts are expanded and synchronized with the DoD Suicide Prevention Office to address the high rates of suicide among service members and veterans, assuring every call to the VA and military crisis lines are promptly answered.
- Amend 38 U.S. Code 1782, Counseling, Training, and Mental Health Services for immediate family members and caregivers to require VA to provide full range of counseling and mental health services for families and caregivers of veterans participating in caregiving, rehabilitation, and medical care for service-connected and non-service connected conditions, including veterans in crisis.
- Monitor VA's and DoD's outreach and policy efforts to address mental health needs of veterans with other-than-honorable discharges.
- Monitor implementation of the Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2) and ensure resources are provided to support all provisions outlined in the law.

Women Veterans. Aggressively invest and implement VA's Strategic Priorities to provide comprehensive primary care, health education, and reproductive health services, improve communication and partnerships, and increase access to gender-specific medical and mental health care to meet the unique needs of women service members and transitioning women veterans. Ensure emphasis on programs for women veterans with special needs, including rural, homebound, and aging veterans as well as women who have lost limbs.

Rural Veterans. Increase funding for the VA Office of Rural Health and ensure mandated outreach efforts in rural and remote areas are implemented as required by the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109- 461).

Caregivers. Ensure full implementation of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) provisions. Extend the Act to include full- time caregivers of catastrophically disabled veterans of conflicts before Sept. 11, 2001. Align the DoD and VA definitions for caregiver support and services, to include qualifying “illnesses.”

Deployment-Related Illnesses and Toxic Exposures Research. Support research on the impact of service members exposed to occupational or environmental toxins or hazardous substances, and/or deployment illnesses resulting from their military service (e.g., burn pit exposure in Iraq and Afghanistan, Camp Lejeune contaminated water, Gulf War Illness). Specifically:

- Ensure health care and benefits are established to appropriately compensate and support veterans, family members and survivors, particularly veterans who experience catastrophic and devastating cancers, diseases, other health conditions, or death.
- Implement September 2016, Government Accountability Office Report (GAO-16- 781) recommendation for DoD and VA to examine the relationship between direct, individual, burn pit exposure, and potential long-term health-related issues as well as the National Academies of Sciences, Engineering, and Medicine’s Report of 2011, which suggested the need to evaluate the health status of service members from their time of deployment over many years.
- Allow surviving family members to add deceased veterans to the Burn Pit or other established registries.
- Monitor implementation of toxic exposure assessment and research provisions contained in the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (P.L. 114-315).

Preventive Health. Eliminate cost share requirements for VA preventive health and medical services to provide equity between VA, DoD TRICARE, and private health insurance providers.

CHAMPVA Young Adult. Expand CHAMPVA to adult children of eligible veterans, family members and survivors until age 26 to align eligibility with TRICARE Young Adult and private sector health insurance.

VHA Access and Fees. Oppose enrollment or access fees for current and future veterans enrolled in VA health care in all priority group categories. Preserve integrity and access to both VA and DoD health systems for dually eligible members.

CLAIMS PROCESSING AND APPEALS SYSTEMS

Integrated Disability Evaluation Benefit Systems. Improve legacy and integrate disability evaluation systems and Benefits Delivery at Discharge efficiency and effectiveness. Continue to press DoD and VA to achieve true interoperability of electronic medical, personnel and benefit records to improve medical outcomes and delivery of benefits.

Presumptive Service Connection. Promote dissemination of ‘brown’ and ‘blue’ water Navy ship logs as they become available for veterans to apply for Agent Orange- related diseases. Support legislation to establish eligibility for presumptive service- connection for ‘blue water’ Navy Vietnam War service members. Ensure fair and consistent application of standards and procedures for adjudicating Agent Orange claims. Encourage expansion of Camp Lejeune water contamination conditions to include all those recognized by DoD in 2012 and provide fair effective dates. Promote the inclusion of affected family members.

Mental Health Discharge Board of Review. Support creation of a Mental Health Discharge Board of Review to redress ‘low-ball’ service member ratings for PTSD, TBI, and MST, including Vietnam War and Gulf War I periods. Support efforts to ensure review boards take circumstances of in-service trauma into consideration.

VA Schedule of Rating for Disabilities (VASRD). Support the continual review and modernization of the VASRD based on current medical science.

PTSD, TBI and MST Compensation and Pension (C & P) Exams. Promote VA’s release of Disability Benefits Questionnaires for PTSD and TBI to allow veterans to obtain C & P exams outside the VA-contract examiners (e.g., from DoD doctors if member is still on active duty or from VA treating physicians).

EMPLOYMENT, EDUCATION AND TRAINING PROGRAMS

Veterans Hiring Incentives. Re-enact employer tax incentives under the Vow to Hire Heroes Act.

Vocational Rehabilitation and Employment (VRE) Benefits. Establish a cost- of-living stipend for VRE participants.

Veteran-Owned and Service Disabled Veteran-Owned Businesses. Ensure veteran-owned and service-disabled veteran-owned businesses achieve parity with other federal contracting categories and ensure all federal departments at least meet established veteran contracting and hiring goals.

Basic Reserve GI Bill Benefits. Urge proportional upgrades to the Title 10 Montgomery GI Bill program (Chap. 1606, 10 USC) to keep pace with the cost of education.

GI Bill Integration for 21st Century Force. Urge hearings for a unified architecture for all GI Bill programs for active duty, Guard and Reserve service members under the principle of awarding benefits according to the length and type of duty performed.

Student Veterans Protections. Support measures to foster positive student-veteran outcomes including:

- Further improving laws to protect veterans enrolled in institutions of higher learning that close or lose their accreditation.
- Aligning VA protections for student-veterans with Departments of Education and DoD protections.
- Ensuring schools spend VA benefits on serving the veteran.
- Extending “90-10” ratio of Federal aid to include GI Bill benefits.

SPECIAL INTEREST ISSUES

Homeless Veterans. Support and expand VA initiatives to reduce and eliminate veteran homelessness.

Veterans’ Preference. Authorize veterans’ preference appeal rights for veterans employed by VA or other federal, state, and local government agencies. Oppose legislation restricting preference currently in law.

Financial and Legal Protections. Support continuous review and upgrades of the Servicemembers’ Civil Relief Act, including elimination of “forced arbitration” clauses in contracts that nullify the Act’s protections. Strengthen re-employment rights for Operational Reservists who support military missions on Title 10 orders. Allow military families to break a lease without penalty when on-post housing becomes available. Make mortgage protection coverage permanent.

Veterans Treatment Courts. Support further expansion of these courts to jurisdictions across the country. Support scaling of services for incarcerated veterans.

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Thank you for the opportunity to present the Association's 2018 legislative initiatives and issues on behalf of the membership of the Non Commissioned Officers Association of the United States of America.

I am pleased to answer any questions at this time.

2018



Non Commissioned Officers Association of the USA

**VINCENT W. PATTON III, Ed.D.
The 8th Master Chief Petty Officer of the Coast Guard, Retired
President and National Commander**

Master Chief Vince Patton, the 8th Master Chief Petty Officer of the Coast Guard, accepted the position of President of the Non Commissioned Officers Association on July 12, 2016 at the NCOA Business Meeting.

A native of Detroit, MI, and the son of one of NCOA's founding members, Master Chief Patton served 30 years of dedicated service in the U.S. Coast Guard, retiring in October, 2002. His illustrious career included staff and operational assignments throughout the country, both afloat and ashore throughout the United States along with a joint military service assignment in Cuba and Haiti. Among his numerous military awards includes the Distinguished Service Medal which is the nation's highest military peace time recognition for performance of duty.

Master Chief Patton served as the 8th Master Chief Petty Officer of the Coast Guard from 1998 to 2002. As the Coast Guard's top senior enlisted leader and ombudsman, he was the principal advisor to the Commandant of the Coast Guard, his directorates, and the Secretaries of Transportation and Defense. Primary focus on quality of life issues, career development, work environment and personnel matters affecting over 45,000 active duty, reserve, and civilian personnel service wide. He routinely addressed these specific issues before appropriate Senate and House committees in Congress, and the Commander in Chief, along with his senior enlisted counterparts of the other four armed services.

Master Chief Patton holds the distinction of having earned all his college education while on active duty. He received his doctorate of education degree from The American University, a master's degree in counseling psychology at Loyola University at Chicago, a B.S. in social work from Shaw College and a B.A. in communication from Pacific College. His extensive military education includes the Department of Defense Equal Opportunity Management Institute, U.S. Sergeants Major Academy, and the Coast Guard Chief Petty Officers Academy.

After his retirement from the U.S. Coast Guard in 2002, he was assistant professor at University of California Berkeley teaching 'Philosophy of Ethics,' for two years, and was also a seminary student, at Graduate Theological Union, earning his Master of Theology in Applied Religious

Studies and becoming an ordained minister. Soon after, he spent seven years with Military Advantage, a division of Monster Worldwide and the world's largest military membership organization known as 'Military.com.'. As Director of Government Partnership & Alliances; then four and a half years as executive director for the Armed Forces Communications and Electronics Association (AFCEA) Educational Foundation. He was also president and CEO and now principal advisor of Warriors4Wireless (W4W), a nonprofit career development program designed exclusively for transitioning military servicemembers and veterans providing them a unique opportunity to become trained for careers in the wireless telecommunications infrastructure industry.

Currently, he is Senior Vice President for leadership development with NewDay USA Financial LLC where he works closely with staff members on their development of leadership and management skills as part of the Character Driven Leadership Program, with special emphasis placed on 'Up & Coming' employees who are entering supervisory roles and responsibilities. In addition, he conducts training seminars on leadership & military introductory subjects through the NewDay University, and is a member to the NewDay USA Foundation Board of Advisors

An NCOA member since 1976, Master Chief Patton is also actively involved with some other public service and nonprofit organizations serving on boards with the National Coast Guard Museum, U.S. Naval Sea Cadet Corps, U.S. Naval Institute, Northeast Maritime Institute and the Uniformed Services Benefit Association.

DISCLOSURE OF FEDERAL GRANTS AND CONTRACTS

The Non Commissioned Officers Association of the United States of America (NCOA), does not currently receive, nor has the Association ever received, any federal money for grants or contracts. Routine allocation of office space, associated resources at Government facilities for outreach, and direct services through its accredited National Veteran Service Officer Program occasionally have been acquired.

**TESTIMONY OF THE
NATIONAL GUARD ASSOCIATION OF THE UNITED STATES**

Senate Committee on Veterans' Affairs

House Committee on Veterans' Affairs

Joint Hearing on Legislative Presentations

March 6, 2018

Chairman Isakson, Ranking Member Tester, Chairman Takano, Ranking Member Roe and other distinguished members of the Senate and House Committees:

Introduction:

On behalf of the almost 45,000 members of the National Guard Association of the United States and the nearly 450,000 soldiers and airmen of the National Guard, we greatly appreciate this opportunity to share with you our thoughts on today's hearing topics for the record. We also thank you for the tireless oversight you have provided to ensure accountability and improve our nation's services to veterans and their families.

In my testimony, I would like to focus on three specific issues impacting Guardsmen that fall under the jurisdiction of this Committee. These issues are: ensuring benefit parity for Guardsmen, improving mental health treatment in order to combat the high rate of suicides across the National Guard, and highlighting legislative initiatives that continue to support and protect Guardsmen, both in their civilian and military careers, as readiness requirements and operational tempo continue to increase.

Duty Status Reform and Benefit Parity

One of the primary legislative goals of NGAUS is to address the benefit disparity for Guardsmen under federal activation authorities. For the past two years, I have addressed this Committee and asked for your assistance in correcting numerous benefits not afforded to the thousands of Guard and Reserve service members deploying under 10 U.S.C. §12304b status. With the passage of the Forever G.I. Bill and the Fiscal Year 2018 National Defense Authorization Act (NDAA) in recent months, Guardsmen and Reservists are now eligible for nearly all of the same benefits as their active duty counterparts, including tuition assistance, transitional healthcare access, and Post-9/11 G.I. Bill benefits. This Committee and its members have been instrumental in closing the benefit gap for our members at a time when the Department of Defense is increasing its utilization of 12304b with more than 13,000 Guardsmen scheduled to deploy around the world over the next two years.

To complete this effort, we ask for your support in tackling the final piece of this benefits parity issue, granting early retirement credit under 12304b orders. While our service members are eager to continue to serve in any capacity, we believe that they should be afforded the same benefits enjoyed by active component members. Beyond just a benefit parity issue; it is a question of fairness for the men and women who choose to serve our nation.

Improving mental health treatment in the National Guard

I would like to convey our extreme concern with the high suicide rate across all components of the military, and focus specifically on the near-epidemic rate of suicides within the Army National Guard. While we greatly appreciate the efforts made by this Committee to begin

addressing suicides across the military and among our veteran population, I think we all agree that much more needs to be done to combat and reduce the rate of suicide.

NGAUS hopes to continue our work with this Committee and the National Guard Bureau to support and bolster specific initiatives to reduce suicides in the National Guard. Before identifying some of these specific initiatives, I would like to point out a few of the challenges we face in combating mental health issues.

Among the Air and Army National Guard, as well as within the 54 states and territories, we have seen numerous examples of inconsistencies in staffing and, perhaps most alarming, programs and key personnel working in silos and not sharing common analysis or reporting systems. We ask for this Committee's support to standardize the various mental and behavioral health programs within the Department of Defense, including in the National Guard Bureau.

In terms of staffing and personnel, there is currently insufficient funding for Army National Guard Directors of Psychological Health (DPH), who provide vitally important counseling services to our members. Research shows the importance and benefits of full-time chaplains at Air and Army Guard units. However, a combined 90 total chaplains across the Guard are unable to meet the needs of nearly 450,000 Guardsmen. We all must do more to ensure that members of the Reserve Component have regular access to guidance and counsel as well as to qualified mental health professionals. Increasing funding for hiring additional Directors of Psychological Health and full-time chaplains is a positive step forward.

Members of the Guard and Reserve struggle to access the same care as their active duty counterparts because they often live far from military installations. For this reason, we ask for your support in pursuing initiatives that utilize new technologies, including access to telehealth services, to deliver care to our most vulnerable members.

Currently, Guardsmen and Reservists undergo annual health assessments to identify medical issues that could impact their ability to deploy, but any follow-up care is often pursued at the expense of our service members. We support Ranking Member Tester's legislation, the CARE for Reservists Act that would allow Guardsmen and Reservists to access Vet Centers for mental health screening and counseling, employment assessments, education training, and other services to help them. We ask for your assistance in pursuing additional legislation that would provide all drilling Guard and Reserve members access to Vet Center counseling services regardless of whether they have been deployed.

While NGAUS continues to support the Department of Veterans Affairs (VA) mental health initiatives, we believe it is essential to establish a network of local, state, and federal resources centered at the community level in order to deliver evidence-based care to veterans whenever and wherever they are located. To leverage innovative mental health care providers in our communities, the VA can exercise its authority to contract with private entities in local communities, or alternatively implement a voucher program that would allow our veterans to seek fee-based treatment locally outside the brick and mortar VA facilities and Vet Centers.

The Military Support Program (MSP) established by the Department of Mental Health and Addiction in the state of Connecticut is one fantastic example of a community-based initiative. We believe the MSP could serve as a successful model for the rest of the nation. For just over \$500,000 annual operating budget, the MSP is available to all service members, veterans and their families in Connecticut. The MSP provides its clients with accessible, convenient and completely confidential counseling services through a geographically dispersed network of over 400 clinicians, as well as the staffing of a 24/7 call center.

The MSP also includes an Embedded Clinician Program, who are civilian providers made available to Connecticut National Guard personnel during their unit's weekend training periods and at any time over the phone. They get to know the unit members and are immediately accessible if a Guardsman needs assistance or would like to schedule follow-on counseling. We believe this program is successful because it focuses on accessibility and convenience for the men and women of the Connecticut National Guard. NGAUS would be more than willing to facilitate the establishment of a collaborative relationship between the Connecticut National Guard, MSP, and this Committee.

While we recognize there is no silver bullet in dealing with a myriad of mental health issues across all components of the military, NGAUS will support all legislative approaches that seek to expand quality, access and affordable healthcare options for our members.

Strengthening Service Member Civilian Employment

As the National Guard remains an integral part of our nation's defense, both at home and abroad. Increased training and readiness requirements combined with more frequent deployments has strained the traditional citizen-soldier construct, placing stressors on both the Guardsmen and their employers.

While I cannot anticipate future operational demands, what is clearly true is that the era of "one weekend a month and two weeks a year" is over. Our members are serving in uniform more days throughout the year and often completing military tasks on civilian time, all while undertaking additional military administrative and training duties due to insufficient levels of full-time support personnel. These duties often compete with their civilian careers and can have significant negative effects. As we continue to increase operational demands on our soldiers and airmen, their

employers are feeling the effects of their extended absence. In the wake of this new reality, we ask that the Committees support continued efforts to assist Reserve Component service members and their employers.

One major effort I would like to discuss with the committee today is the idea of providing zero-cost TRICARE health coverage to the National Guard and Reserve. While this is not an effort that will be concluded this year, I believe very strongly that the time is now to discuss if an Operational Reserve is better served through ensuring guaranteed medical coverage in lieu of the current disjointed system of third party health contractors and Periodic Health Assessments. This year, we will advocate for conducting a study at the Department of Defense into what the cost of such a change in policy would be.

The benefits of zero-cost TRICARE coverage extend beyond medical readiness and well-being for reserve component military families. TRICARE, as one of our top retention policies, will help us keep a manned and ready force. In addition to building medical readiness today, providing preventive care throughout our service members' careers will likely reduce medical expenditures when they transition from drilling Guardsman to Veteran. Further, this will become a significant employer benefit when a CEO or hiring manager knows that this service member won't require health insurance coverage. As we ask more and more of our National Guard and Reserve units in peacetime training, I worry that companies will start to choose equally qualified non-military candidates over our service members simply because they are concerned that the Soldier or Airman will be away too often. We must find a way to better incentivize these companies.

We continue to support legislative efforts that strengthen the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, which protects National Guard members who step away from their civilian jobs to serve their country. Under USERRA, all

uniformed service members are protected within their civilian employment. Guard members may not be discriminated against because of their past, present or future service, including training or deployment. USERRA establishes a right to prompt reinstatement after service and ensures certain health care benefits during and after.

We continue to support Senator Blumenthal's efforts, including last congress' **S. 646**, the Justice for Service members and Veterans Act, which would clarify the procedural rights of Guard members within USERRA. Unfortunately, current USERRA language surrounding forced arbitration is not clear, and there are conflicting court decisions that do not always protect Guard members' procedural rights. NGAUS urges the passage of this common-sense legislation and asks this Committee to champion changes in law to clarify congressional intent, stop misinterpretations, protect our Guard members and grant them due process in these workplace situations.

Unemployment and underemployment also continues to be a concern for our members. We ask for your continued support in passing critical legislation creating pathways to steady employment for Guardsmen. We support Congressman Ryan and Palazzo's legislation, **H.R. 801**, the Reserve Component Employer Incentive, Compensation, and Relief Act of 2019, which grants tax credits to employers who employ members of the National Guard and Reserve. Legislation like this is critical to incentivize National Guard employment as we continue to demand more training time of these citizen soldiers. We also encourage re-introduction and passage of last Congress' **S.1218**, Empowering Federal Employment for Veterans Act of 2017, introduced by Senator Heitkamp, which requires executive agencies to maintain a Veterans Employment Program Office and designate a veteran's employment official.

Finally, we encourage the passage of last Congress' **S. 2235**, the Military Reserve Jobs Act of 2017, introduced by Senators Donnelly and Cruz that would establish a tiered-hiring preference for Reserve Component service members for civil service jobs. **S. 2235** aimed to promote hiring of Reserve Component members into the federal workforce, a critical goal. Each of these bills would prove extremely beneficial to our pursuit of solving the problem of unemployment in the National Guard.

Conclusion:

I thank you all again for allowing NGAUS to testify before the Committees today. The work done here is critical to the well-being of our service members and the success of our National Guard. I look forward to continuing our work together and sincerely appreciate the steadfast leadership from the members and their staffers in advocating for the men and women of the National Guard.

Biography of BG (Ret) Roy Robinson:

Retired Brig. Gen. Roy Robinson succeeded retired Maj. Gen. Gus Hargett as president of the National Guard Association of United States on March 13, 2017.

General Robinson serves as chief executive officer of NGAUS. He is responsible for the association's day-to-day operations in Washington, D.C., and a staff of 28 employees. He also oversees the National Guard Educational Foundation, which maintains the National Guard Memorial Museum, and the NGAUS Insurance Trust.

His principal duties include providing the Guard with unified representation before Congress and a variety of other functions to support a nationwide membership of nearly 45,000 current and former Army and Air National Guard officers.

He came to NGAUS after serving eight years as executive director of the National Guard Association of Mississippi, the nation's largest state Guard association with more than 2,500 members. He simultaneously served as NGAUS vice chairman-Army from 2014 to 2016.

General Robinson has more than 33 years in uniform, much of it while holding a series of full-time sales and marketing positions in the private sector, all of it in the Mississippi Army National Guard. He spent time in every duty status available in the National Guard: Traditional part time, as a state employee, federal technician and in the active Guard and Reserve.

He began his career in 1983 as an enlisted soldier, earning his commission as second lieutenant through the ROTC program at the University of Southern Mississippi in 1985. He retired in 2016 as assistant adjutant general of Mississippi-Army.

Among his military career highlights is commanding the 150th Engineer Battalion (Combat), 155th Armored Brigade Combat Team, during combat operations in Iraq in 2005. He earlier commanded Camp McCain Training Site in Grenada, Mississippi, for 18 months.

In addition to a bachelor's degree in speech communication from Southern Mississippi, General Robinson holds a master's in business administration from Jackson State University. He also completed a U.S. Army War College fellowship in logistics and acquisition at the Center for Strategic Analysis at the University of Texas.

The general holds several military decorations, including the Bronze Star, the Legion of Merit, the Meritorious Service Medal (with four Bronze Oak Leaf clusters), the Combat Action Badge and several Mississippi National Guard awards.

He is married to the former Susan Roth. They have three children and three grandchildren.



TESTIMONY OF

Philip Hilinski, Master Sergeant, US Army (Ret)

National President

THE RETIRED ENLISTED ASSOCIATION (TREA)

Before a

JOINT HEARING

HOUSE and SENATE COMMITTEES ON VETERANS AFFAIRS

March 2019

**Chairmen Isakson, Chairman Takano, Ranking Member Tester and Ranking
Member Roe, and distinguished members of both Committees**

It is an honor and privilege to testify to the Joint Committee to share The Retired Enlisted Association's (TREA) legislative priorities, goals and concerns for FY 2019 to assist you in providing benefits and services to America's veterans and military retirees as well as their families and survivors. TREA looks forward to continuing our strong working relationship with you as Congressional leaders and with your respective staffs to secure the benefits and services our veterans and servicemembers deserve.

TREA welcomes the chance to share our views and help Congress enact laws to improve the lives of men and women who serve to protect our American way of life. Our veterans and military prove every day that freedom is not free and all Americans are thankful and grateful for their service.

I am Philip Hilinski, National President of The Retired Enlisted Association (TREA). TREA was created in 1963 to give the men and women who serve or have served in America's enlisted ranks a voice to speak to our Government. Our members are from all the branches of the Uniformed Services. They serve or have served on active duty, in the Reserves and many spouses or surviving spouses are veterans in their own right, or are members of our Auxiliary. Originally all our members were military retirees or those who were planning to serve a full military career. TREA evolved and opened our membership to all veterans from the enlisted ranks as well as retirees. As a

Congressionally chartered VSO since 1992 with members who were Department of Defense retirees as well as veterans we have always worked on and studied veteran issues.

TREA wishes to thank you as Members of Congress for your leadership on veterans' issues and the dedicated work of both Committee staffs for your active and important oversight of the Department of Veterans Affairs (VA). Your work is crucial and led to the passage of legislation to reforms of VA programs and services. Congress enacted the laws and VA is now challenged to implement the provisions, a truly monumental undertaking requiring both Committees continual and robust oversight and review.

TREA knows that you and your staffs are already working to hold VA accountable to meet the requirements of and to implement three major reforms: 1) Community Care Program -- MISSION Act; 2) Appeals Modernization Act (AMA); and 3) Forever GI Bill. Our testimony will also address the following: 1) Women Veterans; 2) Navy Blue Water Veterans; 3) CHAMPVA at 26; and 4) Survivor Financial Benefits. TREA knows there is more work to be done and stands ready to continue to work with you to protect and improve services to veterans and military members.

VA Community Care – MISSION Act

TREA, and the rest of the Veterans Service Organization (VSO) community provided input to and partnered with Congress to develop reforms in how VA delivers health care, benefits and transition services. Perhaps, the most significant law is the VA MISSION

Act. The Act expands veterans' access to health care through a new community care network program and increases VA's internal capacity to provide care to veterans.

During the 115th Congress, TREA worked with VA, the Administration and you, the Senate and House leadership to address concerns and assure that our members concerns as users of the VA health care system were heard. While not perfect, the MISSION Act is a generally supported stakeholder compromise for eligible veterans to have the opportunity for expanded access to care, if desired, as well as maintaining and improving VA's own health care system. VA's implementation must be **clear and reasonable as well as produce results that are achievable**.

TREA calls on Congress to provide **full funding** for the MISSION Act, so it is properly and effectively implemented. Full funding is especially important to support the private sector care option. Cost estimates for FY 2020 and beyond vary widely, and TREA is closely watching VA's soon to be released budget. Taking funds from VA's health care system to pay for private sector provided care is unacceptable and not an option.

Veterans who use VA, must be protected and assured that funding for their VA provided medical care is not diverted to fund care at private care providers.

On February 22, 2019, VA published new eligibility criteria for eligible veterans to use private sector care providers. The proposed rule outlines who will have access to community care without preapproval, what type of care, and how the care will be paid for. Not all healthcare will be funded by VA without preauthorization. Eligible veterans

must consider other factors and meet specific criteria to trigger entitlement to care under the new access standards.

Under the newly proposed access standards, drive time replaces miles/distance for veterans to use private sector health care options. Veterans who must drive more than 30 minutes to reach their VA mental health or primary care providers - or wait longer than 20 days for an appointment would be allowed to use a private doctor. For specialty care, veterans could go outside VA for medical treatment if a VA provider was longer than a 60-minute drive away or there was longer than a 28-day wait. In most cases, VA remains the primary provider of care and is the lead for coordinating care, including scheduling appointments. Congress must assure that VA consistently applies the standards across the system, as written, the proposed rule does not provide information on how VA will assure consistent application to all veterans.

VA estimates the new rules would extend eligibility for community care from 8 percent of VA patients now to 20 percent for primary care and 30 percent for specialty care. VA estimates costs to increase by \$1.1 billion for fiscal year 2019, ending on September 30. VA confirms funding is available to cover these increased costs through FY 2019. VA needs to reconfirm sufficient funds are present to cover FY 2019 costs and that the FY 2020 budget request contains dollars to fund this increased use.

According to VA, drive times would be calculated according to a private-sector program based on Microsoft's Bing search engine maps. About 600,000 veterans enrolled in VA

health care are eligible for the existing community care programs. The proposed expanded standards will raise that number to between 1.5 million and 2.1 million patients, based on VA's own estimates. VA needs to confirm sufficient funds are present in FY 2020 budget request to fund this potential increased use.

In addition, VA must confirm that private sector care providers are available across the country to furnish primary and specialty care services. Providing access to private care is one piece, however, having private medical care providers in place to actually furnish the care is the greater challenge facing VA. Much can be learned from Choice, as VA had difficulty attracting and retaining private sector providers in some locations.

While the 30-day public comment period ends on March 25, 2019, the access standards will not be implemented until June 2019. VA must still provide answers to questions.

One very important question concerns the text "*if it is in the best medical interest of the veteran,*" which is used throughout the proposed rule. VA's lack of clarity in defining the meaning, leads to the real possibility of some veterans receiving care at one location while others at a different location being denied care. VA must clearly define the text and be consistent in applying that definition across both its system as well as private health care systems.

TREA and Congress know there are no simple answers regarding MISSION Act implementation. TREA will work with the Committee to continue to closely monitor VA's actions and push VA for answers to difficult questions, including:

- 1) Will VA request full funding to cover the cost of the MISSION Act?
- 2) What type of delay in implementation is expected due to contract protests? While VA already awarded contracts for Regions 1, 2 and 3, protests were filed for Regions 2 and 3.
- 3) Will VA communicate with veterans so that billing by private care providers is transparent, efficient and provide VA the ability to track costs? Billing and payments to private care providers must improve based on the issues that surfaced under Choice.
- 4) How will veterans identify participating providers in the private sector and will providers be available to furnish care to veterans in the same manner VA does?
- 5) How will private sector providers share their clinical findings with VA to assure the veterans medical record is complete? Under Choice, VA often learned that private provider records were not added to VA's medical record.
- 6) How will VA provide consistent application of average drive times to address the impact of weather, as well as differences in city and rural traffic patterns? Is the proposed rule too broad? Does it provide VA with too much discretion to apply the standards consistently across the country?

TREA urges VA to be open, timely, and transparent in its communications with VSOs, veterans and Congress at the beginning of its strategic communications.

All are partners and all want to provide the best care and access options for veterans as key decisions are made in implementing the MISSION Act. The overall quality of care provided to veterans must remain at the highest levels and never be compromised.

Just as important, the MISSION Act expands VA's caregiver support program from those with post 9/11 service to all military service eras for seriously injured veterans.

TREA greatly appreciates your strong leadership of and advocacy for the expansion of caregiver provisions. VA must fully fund this expansion of services to pre 9/11 veterans.

TREA is concerned that VA already missed the October 1, 2018, deadline requiring VA to implement an information technology (IT) system to support the caregiver program and allow for data assessment and comprehensive monitoring. VA must correct this immediately and get an IT system running as quickly as possible to cover both current participants as well as those now eligible by expansion.

As VA approaches the October 1, 2019, deadline to certify that the required IT system has been implemented prior to expansion of access to family caregivers of those injured before 9/11, TREA calls on the Committees and Congress to exercise strong oversight and hold VA accountable. VA must provide sufficient resources for the expansion as well as streamline and improve hiring practices for Caregiver Support Coordinators.

Caregivers deserve a robust program that is staffed with the best coordinators and implemented in a timely and efficient manner.

Appeals Modernization Act (AMA)

TREA thanks the Committees and Congress for passing the Appeals Modernization Act (P.L. 115–55). The Act streamlines the appeals process and provides for more efficient quicker decisions.

On February 14, the U.S. Department of Veterans Affairs (VA) discontinued the Rapid Appeals Modernization Program (RAMP). RAMP provided eligible veterans with early resolutions to their appealed claims, ahead of full implementation of the AMA.

Under the AMA, thousands of veterans, some of them stuck in a complex system of trying to obtain benefits from VA, will get new options promised to deliver decisions in days or months, instead of years. VA implemented the new process on February 19, for veterans to appeal their claims for VA disability compensation.

TREA applauds VA's biggest change to appeals in decades. The system was devised by VA, with input at the front end from VSOs, including TREA and lawmakers and approved by Congress in 2017. VA should use this model of collaboration and communication in future implementations of major programs.

According to VA, leaders are hoping the most difficult reviews can still be completed in under a year in the majority of cases. The target for cases which do not go before the

Board of Veterans Appeals is an average of about four months for a final decision. Decisions appealed to the Board under its direct docket will average 365 days. Prior to this new process, appeal resolutions averaged three to seven years.

The new system involves multiple avenues for veterans, including an option to appeal their claims with a higher-level adjudicator or directly with the Board of Veterans' Appeals. Another option is to add information to their claim and appeal it with the same adjudicator who reviewed it. TREA understands VA officials will track the amount of time it takes veterans to get through each option and make that information public to help veterans decide which route to take. IT support for the AMA is crucial and must be closely monitored.

Now that the law is fully implemented Congress and VSOs must continue oversight to assure that VA's ambitious appeals new timelines under the AMA are met, TREA looks forward to working with the Committees to monitor VA's progress on meeting AMA requirements and reducing the time to issue appeal decisions.

Education

TREA is grateful to the Committees for the passage of the Harry W. Colmery Veterans Educational Assistance Act of 2017, also known as the "Forever G.I. Bill," which became Public Law 115-48. The law allows all Purple Heart recipients to receive Post-9/11 GI Bill benefits, makes Fry Scholarship recipients and Purple Heart recipients eligible for the Yellow Ribbon Program, and makes members of reserve components of the Armed Forces who lost eligibility for educational assistance under Reserve Educational Assistance Program (REAP) eligible for the Post-9/11 GI Bill. It also restores Post 9/11

GI Bill eligibility for veterans affected by school closure or disapproval, enhances Post 9/11 GI Bill transferability to dependents, and makes the Post 9/11 GI Bill a lifetime benefit with no expiration date to be used to improve veterans' education and employment prospects at any point in their life.

These are some highlighted provisions and TREA is incredibly grateful for each one. However, VA struggled to implement certain provisions, like the Basic Allowance for Housing (BAH), which proved to be more difficult than expected. Hardships were created for almost 200,000 student veterans who received delayed or incorrect BAH payments. The negative impact on student veterans and the loss of time and money is unacceptable. VA must do better in implementing benefits correctly and that the benefits are being used properly. TREA understands VA has taken corrective actions, learned from its mistakes and beneficiaries have been provided payments to make them whole. TREA continues to watch closely and calls on Congress to do the same. Student veterans deserve nothing less.

TREA signed a letter to Secretary Wilkie on February 14, 2019, with more than 30 other VSOs regarding Oversight of the State Approving Agency Program. The letter highlighted a December 3, 2018, VA Inspector General report, "VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students," concluding that VA will waste an estimated \$2.3 billion over the next 5 years in Post-9/11 GI Bill "improper payments to ineligible colleges," including colleges with deceptive advertising and recruiting prohibited under 38 U.S.C. § 3696.

The Inspector General's concerns are not new. In 2016, Yale Law School published a report, "VA's Failure to Protect Veterans from Deceptive College Recruiting Practices," specifying VA's failure to abide by 38 U.S.C. § 3696. Based on this December 2018 Inspector General's report VA remains out of compliance with the statute, despite numerous federal and state law enforcement actions against colleges for deceiving veterans. This has resulted in significant ramifications to VA and student veterans. TREA remains concerned about ineligible colleges receiving improper GI Bill payments that could be avoided with proper and improved VA oversight. VA must address the IG's findings and comply with the requirements of 38 U.S.C. § 3696.

Women Veterans

TREA supports VA providing increased services women veterans. More women are serving in the military and thus, more women are seeking VA health care services. VA has responded but more needs to be done. Women veterans must have their unique needs met and have access to timely, comprehensive health care at all VA locations.

Women are clearly the fastest growing segment of veterans and by 2040, VA projects women will make up more than 17% of living veterans. VA hospitals and clinics should be designed to be more comfortable for women including more areas of physical privacy. There should be more focus given to specific female medical needs, like full time gynecologists on staff at VA Medical Centers.

TREA thanks you for your leadership in the House to swiftly pass H.R. 840, the Veterans' Access to Child Care Act providing veterans with options to have their children cared for while their mothers and fathers are seeing a VA doctor. TREA urges the Senate to take similar action.

VA reports that women veterans are more intensive users of VA outpatient and mental health services when compared to male veterans and are at higher risk for homelessness and suicide compared to nonveteran women. For example, reports show women veterans suffer from a suicide rate 2.4 times higher than civilian women. VA must identify, study, treat and devote sufficient resources to address these alarming statistics.

VA has made progress in meeting the needs of women veterans but much remains to be done. TREA urges VA to be proactive in conducting research on women's health issues, eliminating barriers to providing services and continuing to recognize the unique health needs of women veterans. Congress must continue to exercise oversight of VA's Women Health Program and work to assure women's that the specialized services are appropriately funded.

Navy Blue Water Vietnam Veteran Act of 2019

TREA continues to strongly support H.R. 299 and is pleased that both the House and Senate Committee on Veterans Affairs will continue to push for Congress to pass the

bill. TREA appreciates your hard work and that you are working to overcome the efforts of two Senators, who blocked a Senate vote in the 115th Congress.

The appeals court in *Procopio v. Wilkie*, reverses a ruling and potentially provides a way for the paying of benefits to approximately 90,000 Navy Blue Water veterans. TREA also appreciates the leadership of Chairmen Isakson and Takano and Ranking Members Tester and Roe in writing to Secretary Wilkie, urging him not to appeal a January ruling by the U.S. Court of Appeals for the Federal Circuit in favor of extending Agent Orange health care and benefits to offshore sailors.

TREA thanks you for your continued support and urges the 116th Congress to not fail these veterans again.

CHAMPVA until the Age of 26

There is continuing debate about who should pay for healthcare and how it should be paid for. During the debate one proposal was embraced by all – to provide coverage to young adults up to the age of 26. Many carriers provide coverage to young adults, until they reach the age of 26, by staying on their parents' healthcare policies. TRICARE, Federal Employee Health Benefit Plans and private insurance plans provide coverage to young adults through the age of 25. Unfortunately, dependents of 100 percent service connected disabled veterans after age 23 are not covered under CHAMPVA. Now is the time to correct this inequity. **TREA strongly urges your Committees and Congress to support legislation to provide CHAMPVA to age 26 coverage to this small group of deserving dependents.**

Survivors Financial Benefits**Concurrent Receipt**

TREA has long believed that retired pay and VA service-connected disability compensation are different benefits and earned for different reasons. Military retired pay is earned by 20 or more years of service while service-connected disability compensation is a benefit used to supplant a veteran's lost earnings. Military retirees who are less than 50% service-connected are required to offset their retired pay with the amount of VA disability received. TREA is pleased to continue to support and work with Members on legislation like H.R. 333 or H.R. 303 to eliminate the offset and permit concurrent receipt of retired military benefits and VA disability benefits.

Survivor Benefit Plan (SBP) Dependency and Indemnity Compensation (DIC)

TREA continues to support efforts and urges Congress to pass legislation to allow military retiree survivors to receive full Survivor Benefit Plan benefits. H.R. 553 in the House and S. 622 would end the deduction of Survivor Benefit Plan (SBP) annuities from Dependency and Indemnity Compensation (DIC) paid to survivors of fallen service members, also known as the "widows tax."

The SBP was enacted into law in 1972. It includes a dollar-for-dollar offset of DIC from SBP, called the SBP/DIC offset, for surviving spouses of retired service members who voluntarily participated in the insurance annuity program, paid premiums, and then died of a service-connected issue. Post-9/11 active duty surviving spouses also are impacted. The offset affects more than 60,000 military surviving spouses.

TREA is well aware that VA pays its DIC program and that correcting this issue is under the jurisdiction of the Armed Services Committees. However, TREA asks you to contact your colleagues so that this injustice is corrected.

Conclusion

The Senate and House Committees on Veteran Affairs lead by example in performing vital work to support our Nation's veterans and military members. TREA understands and thanks each of you for your individual and collective efforts. TREA knows that sharing information and communicating with you and your outstanding staffs helps improve services to veterans.

TREA recognizes that oversight is often a thankless but necessary function of government. While VA is large and often bureaucratic there are literally hundreds of thousands of dedicated employees working every day to provide first-class services to veterans. TREA knows there are areas for improvement, including systems, business models, communications and collaborations.

TREA knows that both Committees will continue to do all in your power to assure the continuing improvement of all aspects of VA's mission. TREA is thankful for your efforts and to be your partner, now and in the future, in working to provide the benefits and services veterans have earned and deserve.

Philip Hilinski is in his first year of a two-year term as National President of The Retired Enlisted Association (TREA). He was elected National President in September 2018, at the last TREA Convention in Florida. Phil joined TREA in 2000 as a member of Chapter 111 in Akron, Ohio. Phil served on the Chapter's Board as President, First Vice President, Treasurer, Secretary, and is its Immediate Past Chapter President. Prior to being elected National President, Phil served on TREA's National Board of Directors focusing on four National Committees: Information Technology; Five-Year Plan; Legislative; and Awards. Phil retired from the US Army in 1994 as an E8. He holds a Bachelors' Degree in Business Administration as well as several certifications in Computer Programming. Philip lives with his wife Judith in Dublin, Ohio.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Retired Enlisted Association (TREA) does not currently receive, nor has it received during the current fiscal year or either of the two previous years any federal money for grants or contracts. All activities and services are accomplished completely free of any federal funding.